

A Changing Landscape: The 2026 Diabetes Update.



Susan Cornell, PharmD, CDCES, FAPhA, FADCES

Professor, Pharmacy Practice (retired)
Experiential Education Specialist
Midwestern University College of Pharmacy
Downers Grove, IL

Diabetes Care and Education Specialist and Consultant
Bolingbrook Christian Health Clinic - Bolingbrook, IL
Will-Grundy Medical Clinic - Joliet, IL



Disclosures and Conflict of Interest

- **Susan Cornell** is a PharmD Advisory Board Member for Novo Nordisk, Inc. and a speaker for Boehringer Ingelheim



Disclosure of AI Use

AI was not used in development of this presentation.



Pharmacist Objectives

At the conclusion of this program, the pharmacist will be able to:

- Describe the latest updates in the ADA diabetes guidelines that influence clinical assessment and therapeutic decision-making.
- Identify recommendations related to screening, monitoring, and risk reduction in diabetes care and management.
- Discuss changes in pharmacologic guidance, including considerations for safety, efficacy, and comorbidity management.
- Recall the elements of an individualized care approach that incorporates current diabetes guideline recommendations into pharmacy practice.



Technician Objectives

At the conclusion of this program, the pharmacist will be able to:

- Describe updates within the latest ADA diabetes guidelines that influence diabetes management in pharmacy practice.
- Identify recommendations related to screening, monitoring, and risk reduction in diabetes care and management.
- List common medication therapies used in managing people with diabetes.
- Recognize ways pharmacy technicians can support collaborative diabetes care, including communication with pharmacists, patients, and other healthcare providers.



Key Abbreviations

- A1C = hemoglobin A1c
- ASCVD = atherosclerotic cardiovascular disease
- BMI = body mass index
- CGM = continuous glucose monitor
- CKD = chronic kidney disease
- CV = cardiovascular
- CVD = cardiovascular disease
- DKA = diabetic ketoacidosis
- DKD = diabetic kidney disease
- DPP-4i = dipeptidyl peptidase-4 inhibitor
- eGFR = estimated glomerular filtration rate
- FPG = fasting plasma glucose
- GIP = glucose-dependent insulintropic polypeptide
- GLP-1 RA = glucagon-like peptide -1 receptor agonist
- HDL = high-density lipoprotein
- HF = heart failure
- HFrEF = heart failure reduced ejection fraction
- HFpEF = heart failure preserved ejection fraction

- HTN = hypertension
- LADA = latent autoimmune diabetes in adults
- LDL = low-density lipoprotein
- MACE = Major Adverse Cardiovascular Event
- MASH = Metabolic Dysfunction-Associated Steatohepatitis
- MASLD = Metabolic Dysfunction-Associated Liver Disease
- MI = Myocardial Infarction
- PPG = postprandial plasma glucose
- SGLT-2i = Sodium Glucose Co-Transporter-2 inhibitors
- SMBG = self-monitoring of blood glucose
- SU = sulfonylurea
- T1D = type 1 diabetes
- T2D = type 2 diabetes
- TIR = time in range
- TG = triglyceride
- TZD = Thiazolidinediones
- UACR = Urine Albumin-to-Creatinine Ratio



Statistics: Diabetes

- Prevalence:

- 40.1 million Americans, or 12% of the population
 - ▶ 39.8 million adults
- 2.1 million Americans have type 1 diabetes
 - ~ 314,000 children and adolescents
 - ~40% of adults with type 1 diabetes are misdiagnosed with type 2 diabetes

- Prevalence in seniors:

- People ≥ 65 account for 28.8%

- Prediabetes:

- 115.2 million Americans age 18 and older had prediabetes
 - ▶ 31.3 million adults ≥ 65 years old

https://www.cdc.gov/diabetes/php/data-research/?CDC_AAref_Val=https://www.cdc.gov/diabetes/data/statistics-report/index.html



Staging of Type 1 Diabetes

IGT - impaired glucose tolerance
IFG - impaired fasting glucose
FPG - fasting plasma glucose
PPG - postprandial glucose

	Stage 1 (pre-diabetes)	Stage 2 (pre-diabetes)	Stage 3 (diabetes)
Characteristics	Autoimmunity	Autoimmunity	New-onset hyperglycemia
	Normoglycemia	Dysglycemia	Symptomatic
	Presymptomatic	Presymptomatic	
Diagnostic Criteria	Multiple autoantibodies	Multiple autoantibodies	Clinical symptoms
		Dysglycemia: IFG &/or IGT	
		FPG 100-125 mg/dl	
	No IGT or IFG	2h PPG 140-199 mg/dl	Diabetes by standard criteria
		A1c 5.7% - 6.4%	



Screening for T1D

- ▶ Not formally done in the United States
- ▶ Who to screen:
 - ▶ Relatives of people with T1D or LADA
 - ▶ People with elevated risk
- ▶ What to screen:
 - ▶ Autoantibodies to glutamic acid decarboxylase -65 (GAD65)
 - ▶ Autoantibodies against insulin (IA)
 - ▶ Islet cell antibody (ICA)
 - ▶ Zinc transporter 8 (ZnT8)

- Positive results:
 - If 1 or more islet antibodies - evaluate for stage 3 T1D
 - If multiple autoantibodies without overt T1D, refer to a specialized center for metabolic staging, education, and approved treatments.
 - If 1 autoantibody - monitor for progression.
 - Repeat antibody testing every 6 months to 3 years (pending age) to assess for seroconversion.





Diabetes Management: Beyond Glucose Lowering



Diabetes Self Management

Lifestyle, including self-care, is the cornerstone of optimal diabetes therapy and outcomes.

► Lifestyle

- Diabetes self-management education
- Healthy eating
- Physical activity
- Sleep behavior
- Weight management
- Tobacco, alcohol, substance use



Lifestyle, including self-care, is the cornerstone of optimal diabetes therapy and outcomes.

- Self-Care

- Self-monitoring

- Blood glucose monitoring
- Continuous glucose monitoring
- Blood pressure checks (home)
- Routine foot inspection (daily)
- Hypoglycemia awareness, frequency, causes, etc.

- A1c (every 3 to 6 months)

- Vaccinations

- Dilated eye exam (annual)

- Dental care (annual)

- Comprehensive foot exam (annual)

- Mental health screenings (annual)

- Depression
- Anxiety
- Distress
- Eating disorders
- Cognition



Tailor Treatment for Social Context

Assess and address disparities in care and outcomes:

- Insurance status
- Race, ethnicity
- Preferred language for health discussions
- Disabilities

Assess Social Determinants of Health (SDOH)

- Food insecurity
- Housing insecurity
- Financial barriers
- Health insurance
- Health care access
- Environmental and neighborhood factors
- Community support and resources

How can you implement this into your pharmacy practice?



Healthy Lifestyle Behaviors: Diabetes Self-Management Education and Support (DSMES); Social Determinants of Health (SDOH)

Goal: Cardiorenal Risk Reduction in High-Risk Patients with T2D (in addition to comprehensive CV risk management)

In people with HF, CKD, established CVD or multiple risk factors for CVD, the decision to use a GLP-1RA or SGLT-2i with proven benefit should be made irrespective of attainment of glycemic goal

+ ASCVD

+ Indicators of high risk

+ HF

Current or prior symptoms of HF with documented HFrEF or HFpEF

+ CKD

eGFR <60 mL/min/1.73 m²
Or Albuminuria (ACR ≥ 3.0 mg/mmol [30 mg/g]). Repeat measurement to confirm CKD

GLP-1 RA with proven CVD benefit
-----OR-----
SGLT-2i with proven CVD benefit

If A1c above target

- If on GLP-1 RA, add SGLT-2i with proven CVD benefit and vice versa
- Pioglitazone (low dose)

SGLT-2i and/or dual GIP/GLP1RA or GLP-1RA with proven benefit in HFpEF & obesity

On max tolerated dose of ACEi/ARB

SGLT-2i with primary evidence of reducing CKD progression
Use SGLT-2i in people with an eGFR > 20 mL/min/1.73 m² (Once started, should continue until dialysis or transplant)
-----Or-----
GLP-1 RA with proven CVD benefit

Mitigating risk of MASLD or MASH - Agents with potential benefit in MASLD or MASH

- GLP-1 RA, dual GIP & GLP-1RA, pioglitazone, or combination of GLP-1 RA & pioglitazone
- Insulin preferred with decompensated cirrhosis

Goal: Achievement and Maintenance of Glycemic and Weight Management Goals

To achieve & maintain glycemic goals:

- Metformin OR agents including COMBINATION for efficacy to reach/keep goals
- Prioritize avoiding hypoglycemia

Efficacy for glucose lowering:

Very High:

Dulaglutide (high dose), Semaglutide, Tirzepatide, Insulin, combo oral, combo injectable (GLP-1 RA + insulin)

High:

GLP-1 RA (not listed above), metformin, SGLT-2i, SU, TZD

Intermediate:

DPP-4i

Weight Management:

Efficacy for weight loss:

Very High:

Semaglutide, Tirzepatide

High:

Dulaglutide, Liraglutide

Intermediate:

GLP-1 RA (not listed above), SGLT-2i

Neutral:

DDP-4i, metformin

Comprehensive Medical Evaluation/Assessment: Focus on Liver Disease

- Metabolic Dysfunction-Associated Steatotic Liver Disease (**MASLD**)
- Metabolic Dysfunction-Associated Steatohepatitis (**MASH**)

~**70%** of people with T2D have MASLD

~**20%** of people with T1D have MASLD



~ **50%** will develop MASH



Adjunctive Therapies For T1D

- Reaching glycemic goals with insulin alone is difficult because of the risk of hypoglycemia.
 - Insulin is associated with weight gain, which in turn increases insulin resistance.
 - Insulin does not address other pathophysiological defects.
 - Alpha cell dysfunction
 - Does not have CV protection
- **> 60% of people with T1D are overweight or obese.**
- Apply obesity management strategies for people with T1D who have obesity.
 - GLP-1 RA
 - Metabolic surgery

Type 1 diabetes no longer a disease of the thin, advice needed. Medscape. Feb 13, 2023
American Diabetes Association. 8. Obesity and weight management. Standards of Medical Care in Diabetes 2026.
Diabetes Care 2026;49(Suppl. 1):S166-S182



Standards of Care: Overweight/Obesity

For people without related diseases or complications

- Behavioral counseling
- Healthy nutritional pattern
- Aerobic and muscle-strengthening activities
- Self-monitoring
- Avoid weight-promoting medications when possible

Goal:

Achievement and maintenance of weight reduction + Prevention of obesity-related diseases and complications

Weight-reducing effect of obesity medication beyond 3% weight loss with lifestyle change alone

High >10%	Moderate (5-10%)	Modest (< 5%)
• Tirzepatide • Semaglutide	• Phentermine-topiramate	• Naltrexone-bupropion • Liraglutide • Phentermine • Orlistat

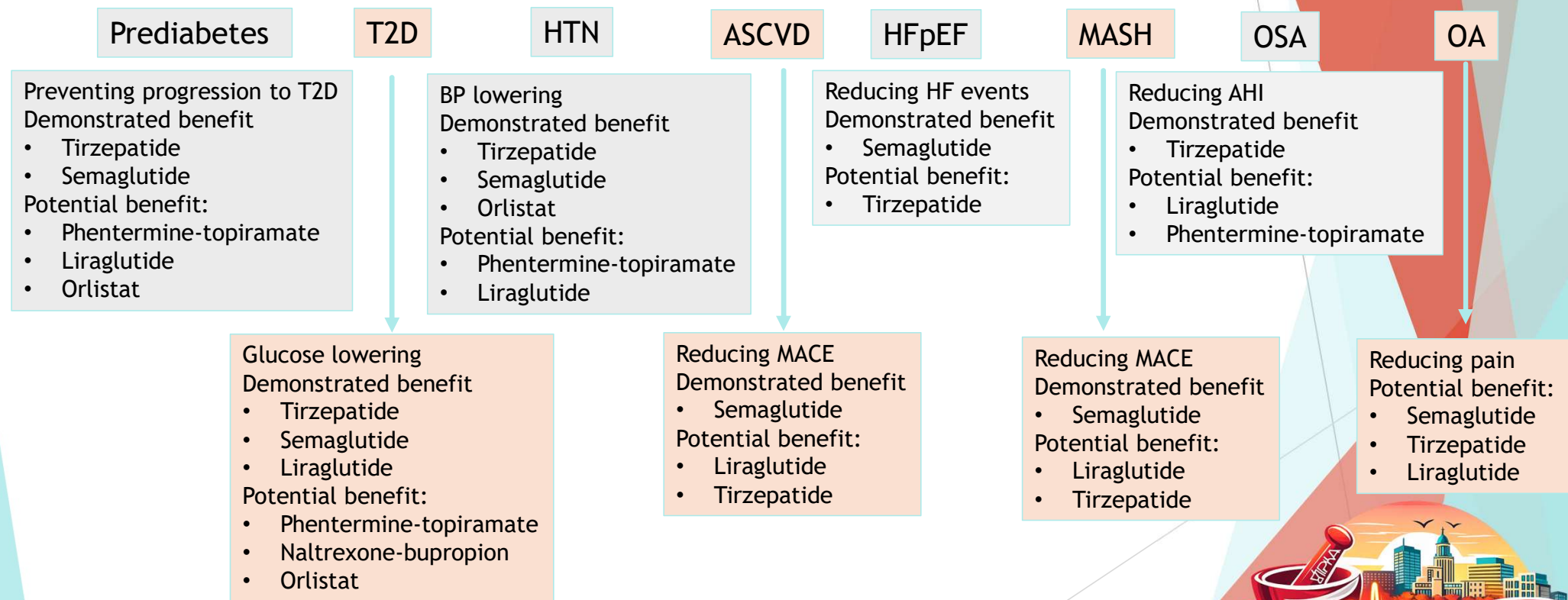
Pharmacologic Treatment of Obesity in Adults: Standards of Care in Overweight and Obesity American Diabetes Association Professional Practice Committee for Obesity



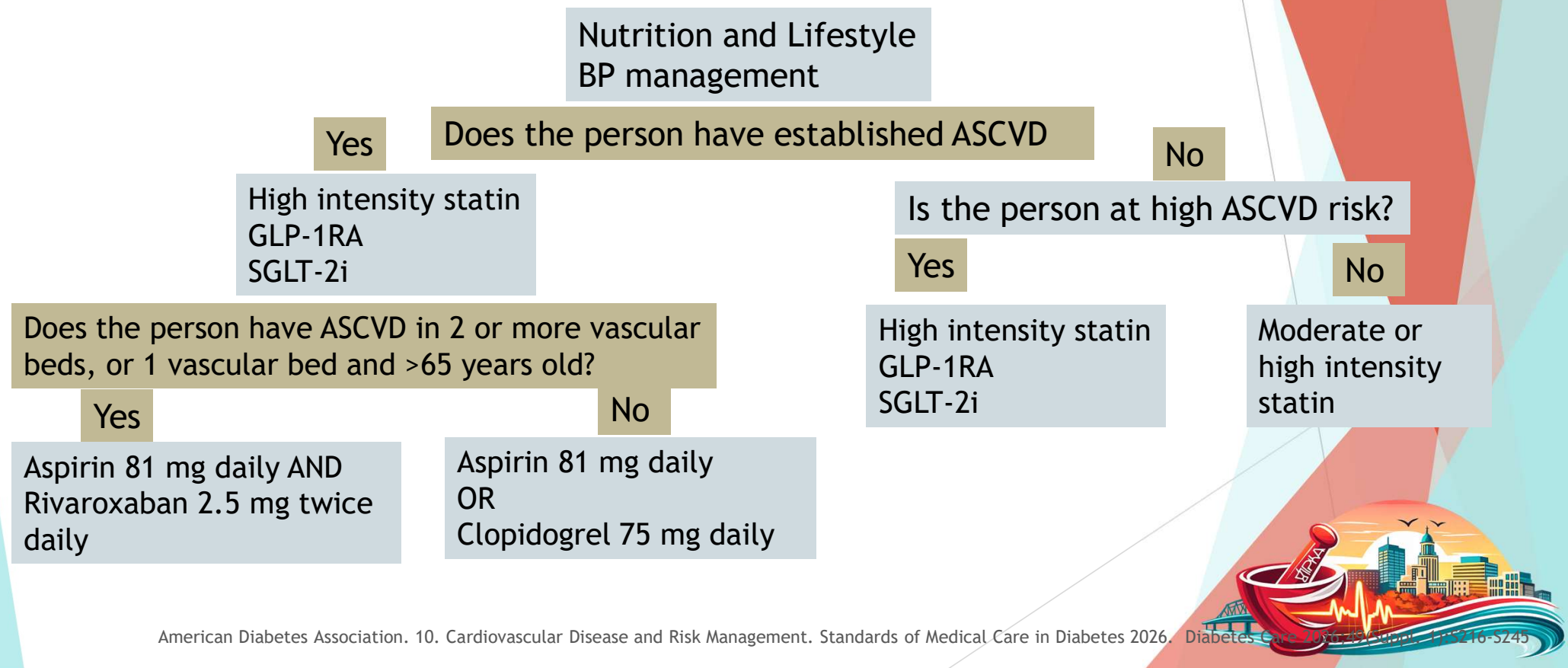
Standards of Care: Overweight/Obesity

Goal: Improvement in obesity-related diseases and complications + Accounting for achievement and maintenance of weight reduction

OSA = obstructive sleep apnea
OA = osteoarthritis
AHI = apnea hypopnea index



Cardiovascular Disease: Prevention of ASCVD in People with T2D



Chronic Kidney Disease

- ▶ Assess kidney function with:
 1. UACR
 2. eGFR
- ▶ Should be done at least annually
 - ▶ In people with T1D with a duration of diabetes of 5 or more years
 - ▶ All people with T2D, regardless of treatment
- ▶ In individuals with CKD, monitor UACR and eGFR at least once and up to four times per year, depending on CKD stage.



How can you implement this into your pharmacy practice?



CKD Classification

CKD Classification based on:			Albuminuria Categories (mg/g)		
- eGFR (mL/min/1.73 m²) (G) - Albuminuria (mg/g) (A)			A1	A2	A3
			Normal to mildly increased	Moderately increased	Severely increased
			<30	30-299	≥300
G1	Normal or high	≥ 90	Screen 1	Treat 1	Treat & refer 2
G2	Mildly decreased	60-89	Screen 1	Treat 1	Treat & refer 2
G3a	Mildly to moderately decreased	45-59	Treat 1	Treat 2	Treat & refer 3
G3b	Moderately to severely decreased	30-44	Treat 2	Treat & refer 3	Treat & refer 3
G4	Severely decreased	15-29	Treat & refer 3	Treat & refer 3	Treat & refer 4+
G5	Kidney failure	< 15	Treat & refer 4+	Treat & refer 4+	Treat & refer 4+

Low risk

High risk

Moderately increased risk

High risk

Very high risk

American Diabetes Association. 11. Chronic Kidney Disease and Risk Management: Standards of Medical Care in Diabetes 2026. Diabetes Care 2026;49(Suppl. 1):S246-S260



CKD Management

RAS = Renin-Angiotensin System

CCB = calcium channel blocker

ns-MRA = Nonsteroidal Mineralocorticoid Receptor Antagonists

Lifestyle Therapy:

Healthy eating, physical activity, smoking/vaping cessation, weight management

Glucose
management

Blood pressure
management

Cholesterol and ASCVD
management

Other agents
with kidney and CV
benefits

First-line
therapy

SGLT2
inhibitor

RAS inhibitor

Statin

Additional
risk-based
therapy

GLP-1 RA

Thiazide
diuretic
and/or CCB

Non-statin,
antiplatelet
agent

ns-MRA



GLP-1 RA Indication Comparison

GLP-1 RA	Glucose-lowering	Cardiovascular Effects		Kidney Effects	Sleep Apnea	Liver disease
		MACE Effect To reduce the risk of death in type 2 diabetes and established CV	Heart Failure	Slow progression of DKD	OSA	MASH
Exenatide	✓					
Liraglutide	✓	✓			?	?
Semaglutide (oral)	✓	✓				
Semaglutide (injectable)	✓	✓	?	✓		✓
Dulaglutide	✓	✓				
Tirzepatide	✓	?	?	?	✓	?

American Diabetes Association. Standards of Medical Care in Diabetes 2026. Diabetes Care 2026;49(Suppl. 1)



GLP-1 RA Side Effects and Tips for Use

▶ Common side effects:

- ▶ Nausea
- ▶ Vomiting
- ▶ Constipation

▶ Other notable side effects:

- ▶ Fatigue
- ▶ Acid reflux
- ▶ Muscle loss
- ▶ “Ozempic face”

Possibly due to improper nutrition

GI effects tend to be dose-dependent

Tips to minimize side effects

Change the timing and size of meal portions

Smaller, more frequent meals

Eat slowly

Consider easy-to-digest foods and beverages

Clear and/or ice-cold drinks

Avoid sweet, fried, and greasy food

Try light, bland foods

(e.g., bread, saltine crackers)

Proper nutrition

Protein, fiber, B12, calcium, vitamin D

Pamulapati LG, Sisson E. Pharmacotherapy for glucose management.
In: Cornell S, Miller DK, Urbanski P, eds. The Art and Science of Diabetes Care and Education. 7th ed. 2026

Five essential nutrients for patients on GLP-1s. Medscape. Sept 26, 2024



SGLT-2 Inhibitor Indication Comparison



SGLT-2 inhibitor	Glucose-lowering	Cardiovascular Effects		Kidney Effects
		MACE Effect To reduce the risk of death in type 2 diabetes and established CV	Heart Failure	Slow progression of DKD
Canagliflozin	✓	✓	✓	✓
Dapagliflozin	✓		✓	✓
Empagliflozin	✓	✓	✓	✓
Ertugliflozin	✓		✓	
Bexagliflozin	✓			
Sotagliflozin			✓	

American Diabetes Association. Standards of Medical Care in Diabetes 2026. Diabetes Care 2026;49(Suppl. 1)



SGLT-2 inhibitors

Most Common Side Effects:

- Weight loss
- Vaginal and male genital infections
- Rash
- Urinary tract infection
- Frequent urination
- Increased thirst
- Dehydration
- GI problems
 - When combined with metformin or a GLP-1 agonist

Tips for Use:

- Educate patients on:
 - Proper genitourinary hygiene
 - Minimize high-acidic foods/beverages
 - Importance of hydration
 - Minimize caffeinated and dehydrating foods/beverages
 - Increase the frequency of urination
 - Signs/symptoms of diabetic ketoacidosis
- Use caution in patients on volume-depleting drugs (e.g., diuretics)



Pharmacotherapy Comparison in CKD in T2D

Pharmacotherapy	Proven Kidney Benefit in CKD and T2D	Proven CVD Benefit in CKD + T2D	Proven Kidney Benefit in CKD
SGLT2 inhibitor	Yes	Yes	Select agents
GLP-1 RA	Yes	Yes	Select agents
RAS inhibitor	Yes	Yes	Yes
ns-MRA	Yes	Yes	Yes
Statin	Neutral	Yes	Yes

American Diabetes Association. 11. Chronic Kidney Disease and Risk Management: Standards of Medical Care in Diabetes 2026. Diabetes Care 2026;49(Suppl. 1):S246-S260



Candidates for GLP-1 RA and/or SGLT-2i

- ▶ High risk or established atherosclerotic cardiovascular disease (ASCVD)
- ▶ HF and/or CKD
- ▶ Risk of MASLD or MASH
- ▶ Benefit from weight loss
- ▶ Hypoglycemia is a concern
- ▶ Have good medication insurance coverage, cost is not an issue, and are candidates for medication rebates/coupon cards



What about Metformin or Insulin???



Metformin:

Candidates for Metformin:

- Need sufficient A1c lowering
 - Up to 2%
- Hypoglycemia is a concern
- Cost is an issue

Common side effects:

- Nausea
- Diarrhea
- Flatulence
- Lactic acidosis
- Metallic taste
- B-12 deficiency

Renal considerations

eGFR 45 - 60 mL/min/1.73 m ²	Continue therapy, monitor renal function every 3 - 6 months
eGFR 30 - 45 mL/min/1.73 m ²	Avoid initiation of metformin If already using, consider dose adjustment to max of 500mg BID
eGFR < 30 mL/min/1.73 m ²	Do not use / discontinue use



ADA Recommendations for Insulin Use in T2D

- ▶ **Recommendation 9.15:** Treatment modification (intensification or deintensification) for adults not meeting individualized treatment goals should not be delayed.
- ▶ **Recommendation 9.20:** In adults with type 2 diabetes (T2D), initiation of insulin should be considered regardless of background glucose-lowering therapy or disease stage if symptoms of hyperglycemia are present or when HbA_{1c} or blood glucose (BG) levels are very high (ie, HbA_{1c} >10% or BG ≥300 mg/dL).
- ▶ **Recommendation 9.22:** If insulin is used, combination therapy with a glucose-like peptide-1 receptor agonist (GLP-1 RA), including a dual glucose-dependent insulinotropic peptide (GIP)/GLP-1 RA, is recommended for greater glycemic effectiveness as well as beneficial effects on weight and hypoglycemia risk for adults with T2D. Insulin dosing should be reassessed upon addition or dose escalation of a GLP-1 RA or dual GIP/GLP-1 RA.



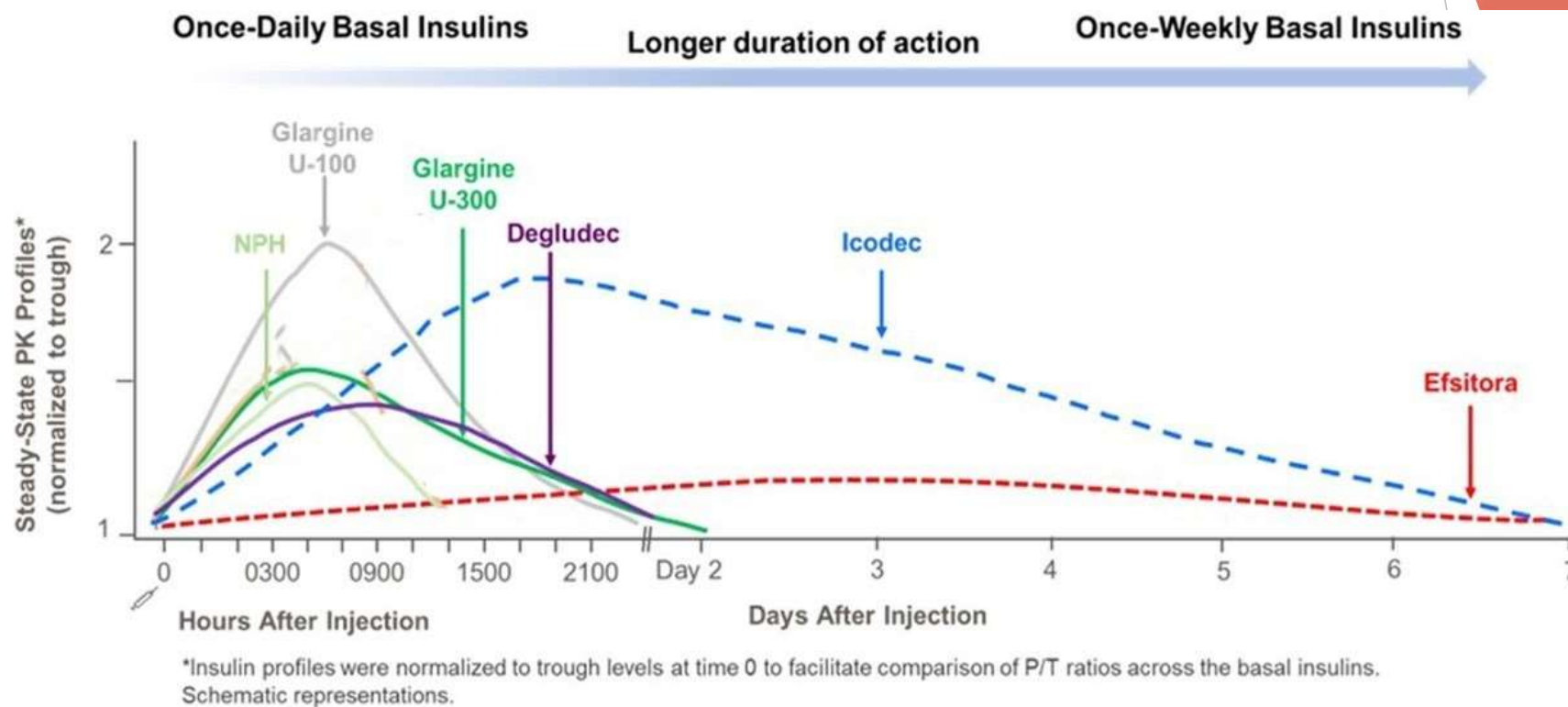
Overcoming Barriers to Insulin Therapy

- Avoid using insulin as a “threat,” but as a solution.
- Ask the person, “What are your thoughts about starting insulin?”
- Give a “limited” trial of insulin.
 - Explain that just because insulin is started, it does not mean the patient needs to be on it forever.
 - Deprescribing insulin happens.
- Use insulin pens and treatment plans that offer maximum flexibility.
- Have the person self-inject in the office (to observe technique).
- Educate on how to recognize and treat hypoglycemia.



Pharmacokinetic Profile of Emerging Basal Insulins

P/T = peak-to-trough
PK = pharmacokinetic



Pieber TR et al. *Endocr Pract.* 2024;30(9):863-869, Rosenstock J et al. *Endocr Rev.* 2024;45(3):379-413.



Cardio-renal comparison

	Metformin	DPP-4 inhibitors	TZD's	SU's	Insulin
Composite MACE	Benefit ??	Neutral	Benefit ??	Neutral	Neutral
Hospitalization for heart failure	Neutral	↑ risk ??	↑ risk	Neutral	Neutral
Renal outcomes	Neutral	Neutral	Neutral	Neutral	Neutral



Person-Centered Treatment Plans: Case Studies



Case #1: Chris (54 Years Old)

Chris is a regular customer at your pharmacy.

- Finance manager at a large company
- Eats 3 healthy meals daily and avoids snacking
- Drinks 2-3 cups of coffee daily
- 1-2 glasses of wine on weekends
- Denies smoking/vaping/cannabis use
- Insurance with prescription coverage for most diabetes medications/devices

Medical History/Current Medications:

- T2D Metformin 1000 mg twice daily
- Hypertension Lisinopril 10mg daily
- Dyslipidemia Atorvastatin 40 mg daily
- Sleep apnea None

A pharmacy technician performs point-of-care (POC) testing and obtains vitals.

Chris brings a copy of their recent labs.

POC at Pharmacy	
Height	5 ft 10 in
Weight	234 lb.
Blood pressure (sitting)	124/78 mm Hg
Heart rate	58 bpm
FPG	192 mg/dL
A1C	8.1%
Recent labs	
LDL	108 mg/dL
HDL	40 mg/dL
TG	175 mg/dL
eGFR	>78 mL/min/1.73 m ²
UACR	20 mg/g

Chris' Ambulatory Glucose Profile

1 - CGM Active

4 - Glucose Variability

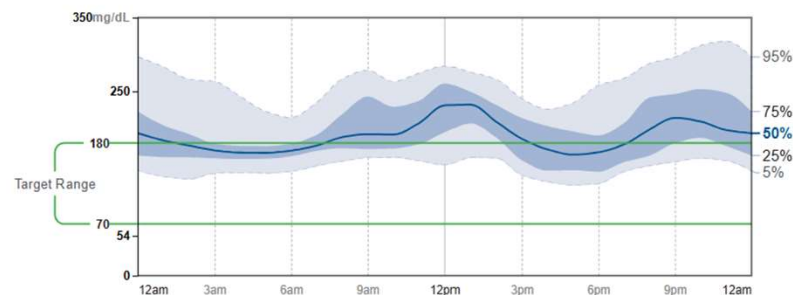
AGP Report

January 16, 2025 - January 29, 2025 (14 Days)

GLUCOSE STATISTICS AND TARGETS	
January 16, 2025 - January 29, 2025	14 Days
Time CGM Active:	98%
Ranges And Targets For	Type 1 or Type 2 Diabetes
Glucose Ranges	Targets % of Readings (Time/Day)
Target Range 70-180 mg/dL	Greater than 70% (16h 48min)
Below 70 mg/dL	Less than 4% (58min)
Below 54 mg/dL	Less than 1% (14min)
Above 180 mg/dL	Less than 25% (6h)
Above 250 mg/dL	Less than 5% (1h 12min)
Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.	
Average Glucose	194 mg/dL
Glucose Management Indicator (GMI)	8.0%
Glucose Variability	21.1%
Defined as percent coefficient of variation (%CV); target ≤36%	

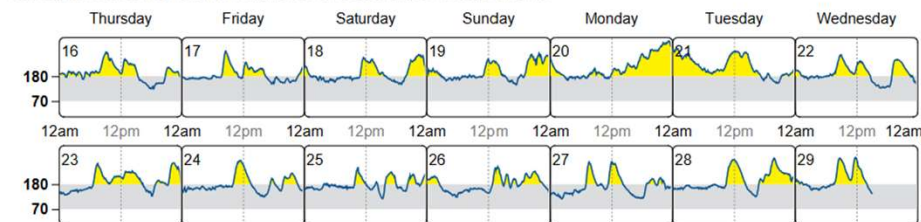
AMBULATORY GLUCOSE PROFILE (AGP)

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



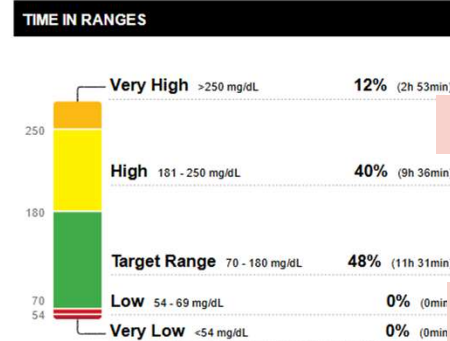
DAILY GLUCOSE PROFILES

Each daily profile represents a midnight to midnight period with the date displayed in the upper left corner.



Source: Battelino, Tadej, et al. "Clinical Targets for Continuous Glucose Monitoring Data Interpretation: Recommendations From the International Consensus on Time in Range." Diabetes Care, American Diabetes Association, 7 June 2019, <https://doi.org/10.2337/doi19-0028>.

LibreView



3 - Hyperglycemic Events

2 - Hypoglycemic Events

5 - Median Curve

6 - Daily Profiles

Is an intervention needed?

What medication and/or lifestyle adjustments would you recommend, if any?



Case #2: Maria (57 Years Old)

- Maria is a restaurant server.
- Eats small breakfast, large lunch and large dinner. She tries to avoid snacking.
- Drinks 1-3 cup of coffee daily
- Denies alcohol, smoking/vaping/cannabis use
- She has lost 20 lbs over the past 6 months
- She does “quite a bit of walking” and is “on her feet all day” at work.
- Complains of stress frustration with her health. She knows she needs to lower her sugar but says “it’s not easy. I wish there were a magic pill to make my diabetes go away.”

Medical History/Current Medications:

- T2D
- Metformin 1000mg twice daily
(She skips doses ~ 3 times per week when she feels bloated or is late for work.)
 - Semaglutide 1.0mg once weekly (on Wednesdays)

- Dyslipidemia
- Rosuvastatin 10 mg daily

OTC / self-care medications:

- Vitamin B-12 - 1000mg daily
- Beet vitamin gummies - 2 gummies daily

A pharmacy technician performs point-of-care (POC) testing and obtains vitals.
Maria brings a copy of their recent labs.

POC at Pharmacy	
Height	5 ft 5 in
Weight	175 lb.
Blood pressure (sitting)	120/68 mm Hg
Heart rate	72 bpm
FPG	305 mg/dL
A1C	10.5%
Recent labs	
LDL	110 mg/dL
HDL	40 mg/dL
TG	145 mg/dL
eGFR	>68 mL/min/1.73 m ²
UACR	55 mg/g

Maria's AGP report

GLUCOSE STATISTICS AND TARGETS

June 2, 2026 - June 15, 2026 14 Days

Time CGM Active: 98%

Ranges And Targets For	Type 1 or Type 2 Diabetes
Glucose Ranges	Targets % of Readings (Time/Day)
Target Range 70-180 mg/dL	Greater than 70% (16h 48min)
Below 70 mg/dL	Less than 4% (58min)
Below 54 mg/dL	Less than 1% (14min)
Above 180 mg/dL	Less than 25% (6h)
Above 250 mg/dL	Less than 5% (1h 12min)
Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.	

Average Glucose 295 mg/dL

Glucose Management Indicator (GMI) 10.4%

Glucose Variability 27.6%

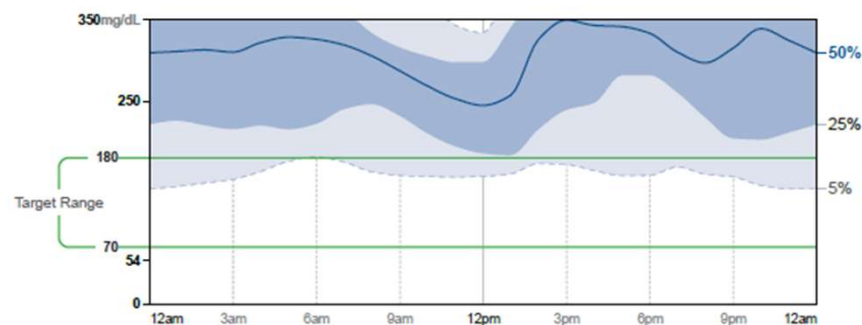
Defined as percent coefficient of variation (%CV); target ≤36%

TIME IN RANGES



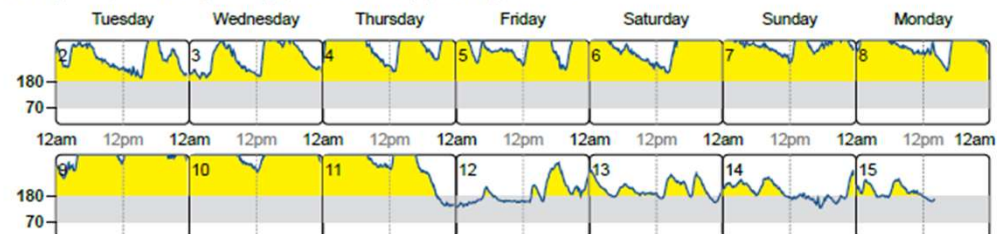
AMBULATORY GLUCOSE PROFILE (AGP)

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



DAILY GLUCOSE PROFILES

Each daily profile represents a midnight to midnight period with the date displayed in the upper left corner.



Key Take-Away Points

- ▶ Diabetes care and management is continually evolving.
- ▶ Diagnosing the correct type of diabetes is critical to proper treatment.
 - ▶ Screening for T1D
- ▶ Lifestyle, including self-care, is the cornerstone to optimal diabetes therapy and outcomes.
- ▶ Individualized, person-centered therapy plans are needed for optimal outcomes.
- ▶ Pharmacotherapy needs to look beyond glycemic management and consider:
 - ▶ **Cardio-renal-liver-metabolic risk / benefit**
 - ▶ **Weight management risk / benefit**
 - ▶ **Hypoglycemic risk**
- ▶ Insulin is the best option in T2D when A1c >10% and/or when not meeting treatment goals.



Thank You for Your Participation.
What Questions Can I Answer For You



thank you!

[Susan Cornell](mailto:scorne@midwestern.edu)
scorne@midwestern.edu

