LOUISIANA DEPARTMENT OF HEALTH

Diabetes ECHO

February 12, 2026

Welcome

Disclaimer

The Louisiana Department of Health (LDH) employees, contractors, affiliates, et al. have no actual or potential conflict- of- interest in relation to this program presentation. The content herein is intended for general guidance, not as legal advice.

Laws and regulations take priority if there are any differences. Only LDH's Secretary or Surgeon General can give official statements. LDH cannot speak for other government agencies, and if you need legal advice, you should consult a lawyer.

Agenda

1. Introductions (5 minutes)
2. Case Presentation (10 minutes)
3. Clarifying Questions (10 minutes)
4. Recommendations (10 minutes)
5. Didactic Presentation (20 minutes)
6. Wrap Up & Announcements (5 minutes)

Introductions

Case Presentation

Diabetes ECHO Case Presentation Template

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

Complete **ALL ITEMS** on this form and email to: *wellahead.projectecho@la.gov*

Sessions held every other Thursday at 12:00PM Central Time

Presenter Name and Credentials: **Dragana Lovre, MD**

ECHO ID # (*for internal use only*):

Presenter Email: **dlovre@tulane.edu**

Clinic/Facility Name: **University Medical center new orleans**

Clinic/Facility Parish: **Orleans**

Remember! Do not include any patient identifiable information on this form.

A confidential ECHO ID number that must be utilized when identifying the patient during the session will be assigned.

The case presentation template will be displayed during the session.

Please avoid using "diabetic", "compliant", "adherent", or "control" when presenting people who have diabetes. Instead, "person with diabetes", "diabetes-related", and "he takes his medications about half the time".

We will all learn and practice together - thanks for your support!

Demographics

Case Type: New

Patient Age: 39

Designated Sex: Female

Race: White/Caucasian

Ethnicity: Not Hispanic/Latinx

Primary Insurance: none

Secondary Insurance: none

Language: Interpreter Required? English / No

Medical History

Symptoms: Pain due to abscess leading to a hospitaliztion

Diabetes Type? Type 2

Year of Diagnosis: 2020

Years on Insulin: <1

Family History of Diabetes/CAD: Yes

Other Medical History:

Select

CLEAR CONDITIONS

ADD CONDITION

Obesity

If Other, please specify:

Recent Hospitalizations? Yes

If yes, please describe:

Pt hospitalized with a buttock abscess and found to have A1c of 10.9%, sent home on insulin and comes in to endo clinic for her first appt

To add to the patient medical history, select a condition from the drop-down below and click "Add Condition." To clear all conditions, click on "Clear Conditions."

Medications

Medication Allergies:

Current Medications/Vitamins/Herbs/Supplements: *Please list generic medication rather than brand name.*

	Medication (generic) Name	Dosage & Frequency		Medication (generic) Name	Dosage & Frequency		Medication (generic) Name	Dosage & Frequency
1.	NPH insulin	40 units in am	Select	6.		Select	11.	Select
2.	NPH insulin	20units pm	Select	7.		Select	12.	Select
3.	Metformin 500mg	daily	Select	8.		Select	13.	Select
4.			Select	9.		Select	14.	Select
5.			Select	10.		Select	15.	Select

Technology

Insulin Pump: No

CGM? No **If yes, Type:** Select One

Pump Readings Attached? Select One

Self-Reported Data? Yes

Blood Glucose Monitoring: Yes

Times Checked/Day: 4

Average Blood Glucose: 170-220

Hypoglycemic episodes/week since last encounter: 0

WELL-AHEAD

Project ECHO

Vitals, Screenings & Labs

Date:

Heig ht:

Weig ht

Select Unit

BMI: 32

Systolic BP: 120

Diastolic BP: 80

Pulse: 80

Microvascular Screening Results

Dilated Eye Exam/Retinal Scan:

Select One

Comprehensive Foot Exam:

Select One

Urine Albumin to Creatinine Ratio:

Select One

Sexual Dysfunction Screening:

Select One

ASCVD (Atherosclerotic Cardiovascular Disease)Risk:

If Other, please describe:

Labs

Date:

HbA1c: Current 10.9%

Previous none

Date:

Total Chol. 232

Triglycerides 300

HDL 35

LDL 137

Date:

Glucose

BUN

Creatinine

GFR 90s

Potassium

Date:

ALT 20s

AST 20s

TSH 3

Proteinuria

Select One

Other Relevant Labs:

none

WELL-AHEAD

Project ECHO

Social History

Marital Status: Single | Education: High School/GED | Literacy Level of Caregiver: Adequate | Income Source: Part-Time Work

Housing: Secure | If Other,please describe: Lives with a roomate who is a friend | Household Size: 1

Other information relative to this patient's case:

Social Support/Patient Strengths

Mostly roomate intown but family out of town

Health Beliefs/Cultural Considerations

Patient with family history of diabetes and complicaitons of diabetes that she does not want to experience

Social Determinants of Health

Able to drive to appts

Works part time (2 jobs) and does not have any insurance assistance due to making just enough money to not qualify

Substance Use

Substance Use History: Does the patient have any history of substance misuse? **No**

Does Patient Use Tobacco Products? **Yes**

Does Patient Drink Alcohol? **No**

If Yes, Number of Drinks/Week?

Substance Use History:

Psychiatric History

Depression: **No**

PHQ9 Done: **No**

PHQ9 Date:

PHQ9 score:

Suicidality? **No**

Diagnostic and Treatment History:

Nutrition

Number of meals per day: 3

Frequency of dining out/week: 1

Does Patient Count Carbs? Yes

Who shops for groceries? Patient

If Others, please describe:

Dining out: What types of dining establishments does the patient frequent? (Select all that apply from the drop-down below)

Home-cooked

ADD DINING OPTION

CLEAR ALL DINING OPTIONS

Home-cooked

Barriers: Are there any barriers to healthy eating for the patient? (Select all that apply from the drop-down below)

Select

ADD BARRIER

CLEAR ALL BARRIERS

no

If Other, please describe:

Does not dine out maybe once a week since her hospitalization

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Project ECHO

Physical Activity

Frequency (# of times/week): **0**

Average Duration (minutes): **0**

Average Intensity: **Select One**

Are there any barriers to exercise for the patient?
(Select all that apply from the drop-down below)

Time

ADD BARRIER

CLEAR ALL BARRIERS

Other Barriers:

Comments

Primary Questions: **Patient in clinic for her first visit after hospitalization. Her abscess has healed. In the hospital she was told she has diabetes A1c of 10% and she is on insulin and metformin. She has no insurance now.**

Patient Goals: **Wants to control glucose and get off of insulin**

Other Comments: **Let's come up with a plan for her and also let's come up with a plan for someone like her that has insurance if we have time.**

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Clarifying Questions

Recommendations

Didactic Presentation

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ADA STANDARDS OF CARE - 2026

Meeta Bhalla, MD, MPH

Endocrinology

2/12/2026

Speaker:
Meeta Bhalla, MD, MPH
Endocrinology

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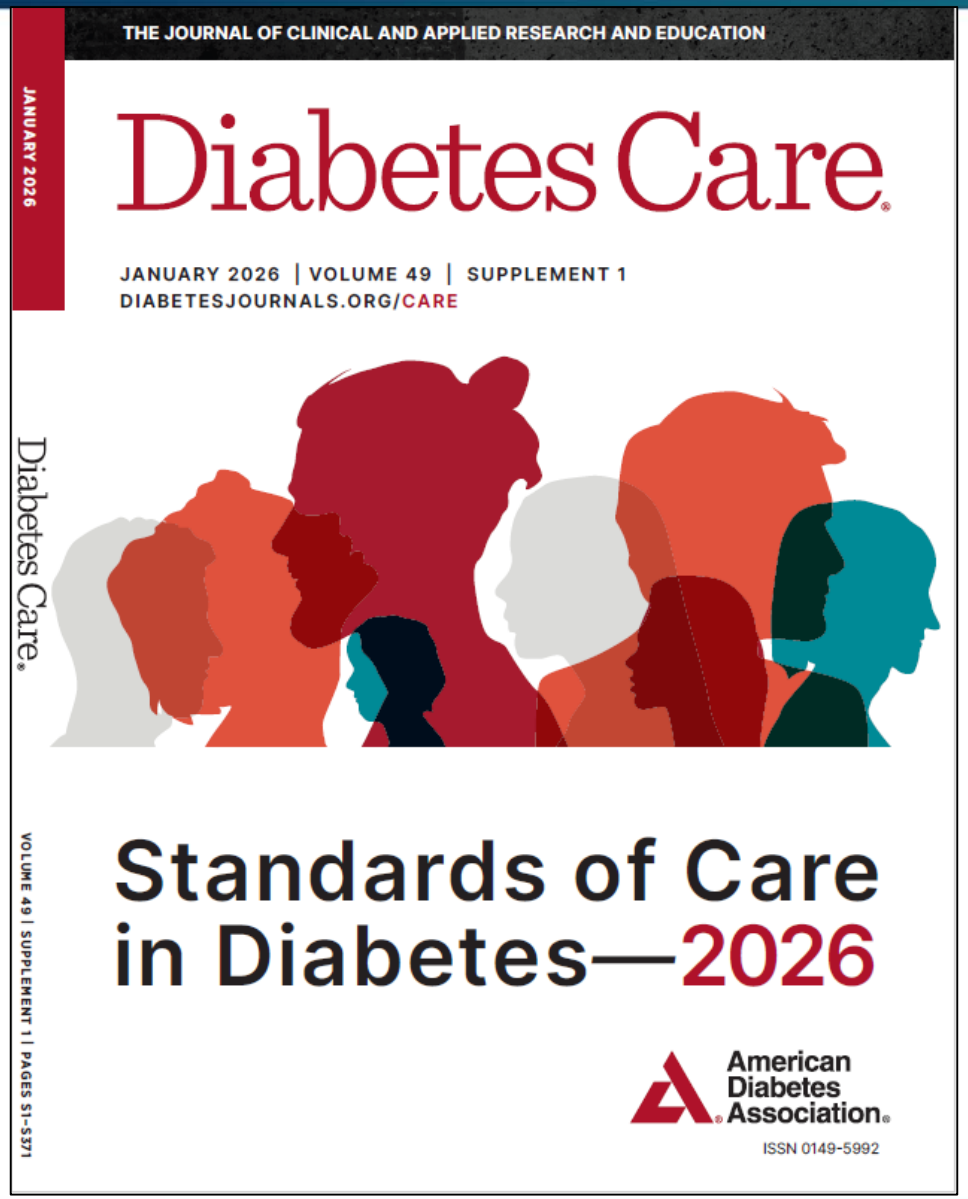
Disclosures

- In the past 24 months, I have NOT had any financial relationships with any ineligible companies.

Objectives

- Understand core areas of diabetes management as per ADA standards of care
- Define standards of care as related to core areas of diabetes management
- Describe latest updates to ADA standards of care


THE JOURNAL OF CLINICAL AND APPLIED RESEARCH AND EDUCATION
JANUARY 2026
Diabetes Care
JANUARY 2026 | VOLUME 49 | SUPPLEMENT 1
DIABETESJOURNALS.ORG/CARE
Diabetes Care
Standards of Care in Diabetes—2026
American Diabetes Association
ISSN 0149-5992
VOLUME 49 | SUPPLEMENT 1 | PAGES S1–S371

Evidence-Grading System

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Table 1—ADA evidence-grading system for "Standards of Care in Diabetes"

Level of evidence	Description
A	Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered, including: • Evidence from a well-conducted multicenter trial • Evidence from a meta-analysis that incorporated quality ratings in the analysis Supportive evidence from well-conducted randomized controlled trials that are adequately powered, including: • Evidence from a well-conducted multicenter trial • Evidence from a meta-analysis that incorporated quality ratings in the analysis
B	Evidence from randomized controlled trials with an identified flaw that may limit validity of the results Supportive evidence from well-conducted cohort studies, including: • Evidence from a well-conducted prospective cohort study or registry • Evidence from a well-conducted meta-analysis of cohort studies Supportive evidence from a well-conducted case-control study
C	Supportive evidence from poorly controlled or uncontrolled studies, including: • Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results • Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls) • Evidence from case series or case reports Conflicting evidence with the weight of evidence supporting the recommendation
E	Expert consensus or clinical experience

Introduction:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S1-S5

Diagnostic Criteria

	Pre-Diabetes	Diabetes
Hemoglobin A1C	5.7–6.4%	≥6.5%
Fasting plasma glucose	100-125 mg/dL	≥126 mg/dL
2h-plasma glucose during OGTT	140-199 mg/dL	≥200 mg/dL
Classic symptoms+Random plasma glucose	-	≥200 mg/dL

Glycemic Goals

Table 6.3—Summary of glycemic recommendations for many nonpregnant adults with diabetes	
A1C	<7.0% (<53 mmol/mol)*†
Preprandial capillary plasma glucose	80–130 mg/dL* (4.4–7.2 mmol/L)
Peak postprandial capillary plasma glucose‡	<180 mg/dL* (<10.0 mmol/L)

Diagnosis and Prevention

- Classify people with hyperglycemia into appropriate diagnostic categories to aid in personalized management. E

- Autoantibody-based screening for presymptomatic T1D should be offered to those with family history of T1D or otherwise known elevated genetic risk. B

Diagnosis and Prevention updates

- **2.9** Individuals with a single confirmed IA-2 autoantibody should be monitored similarly to individuals with multiple islet autoantibodies, as IA-2 autoantibody positivity is an independent risk factor for progression. **B**

Diagnosis and Prevention updates

- **2.9** Individuals with a single confirmed islet autoantibody should undergo repeat antibody testing every 6 months to 3 years (depending on age) to assess for persistence or seroconversion. **E**

Monogenic Diabetes Syndromes

2.29a Regardless of current age, all people diagnosed with diabetes in first 6 months of life should have genetic testing for neonatal diabetes. **A**

2.29b Children and young adults who do not have typical characteristics of T1D or T2D and have family history of diabetes in successive generations (suggestive of AD pattern of inheritance) should have genetic testing for MODY. **A**

Diagnosis and Prevention updates

- **2.18** Monitor postprandial or random glucose levels with recurrent or long-term use of glucocorticoids. B

Pharmacologic Interventions to Delay T2D

3.7 Metformin for the prevention of T2D should be considered in adults at high risk of T2D, especially those aged 25–59 y with BMI ≥35 kg/m^2, higher fasting plasma glucose (e.g., ≥110 mg/dL), and higher A1C (e.g., ≥6.0%), and in individuals with prior GDM. **A**

Pharmacologic Interventions to Delay T2D

3.8 Consider using metformin to prevent hyperglycemia in high-risk individuals treated with a PI3Kα inhibitors (e.g., alpelisib and inavolisib). **B**

Pharmacologic Interventions to Delay T2D

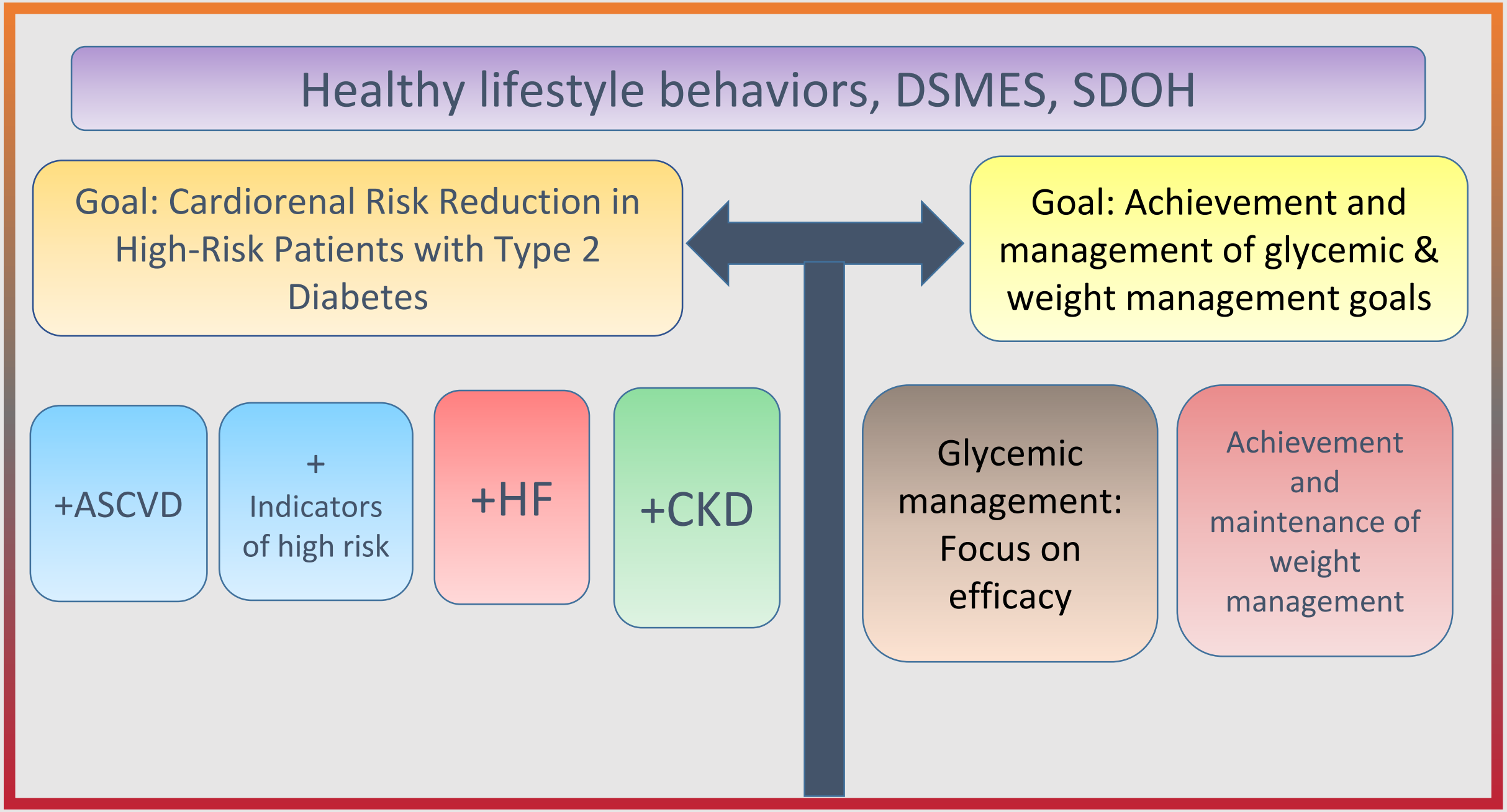
3.9 Consider using metformin to prevent hyperglycemia in high-risk individuals treated with high-dose glucocorticoids. **B**

Hypoglycemia Assessment, Prevention, and Treatment

6.17 First aid kits should include oral glucose for use in treating hypoglycemia. **C**

Hypoglycemia Assessment, Prevention, and Treatment

6.16 Glucagon should be prescribed for all individuals taking insulin or at high risk for hypoglycemia. **A** Family, caregivers, school personnel, and others providing support to these individuals should know its location and be educated on how to administer it. Glucagon preparations that do not have to be reconstituted are preferred. **B**

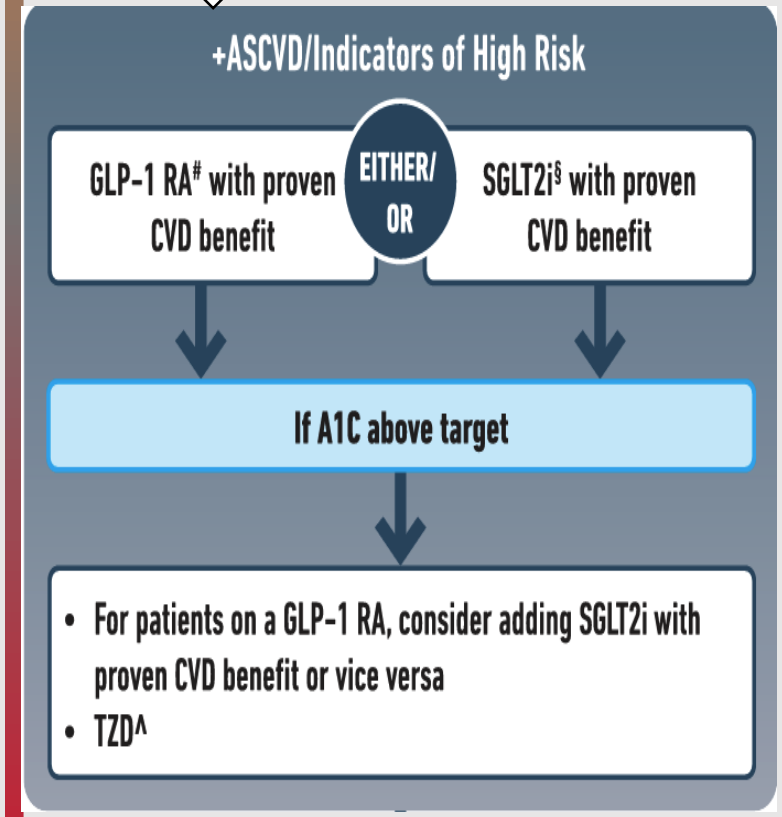

Healthy lifestyle behaviors, DSMES, SDOH
Goal: Cardiorenal Risk Reduction in High-Risk Patients with Type 2 Diabetes
Goal: Achievement and management of glycemic & weight management goals
+ASCVD
+ Indicators of high risk
+HF
+CKD
Glycemic management: Focus on efficacy
Achievement and maintenance of weight management

+ASCVD

\+ Indicators of high risk

+HF

+CKD



SGLT2i

Use SGLT2i in people with an eGFR ≥ 20 mL/min

----------OR----------

GLP-1 RA if SGLT2i is not tolerated or C/I

Glycemic management: Focus on efficacy

Achievement and maintenance of weight management

+ASCVD

+ Indicators of high risk

+HF

+CKD

Mitigating risk of MASLD or MASH: Agents with potential benefits – GLP-1 RA, dual GIP/GLP-1 RA, GLP-1 RA +Pioglitazone
Use insulin in decompensated cirrhosis

Glycemic management: Focus on efficacy

Very High
Dulaglutide, Semaglutide, Tirzepatide,
Insulin, Combination injectable (GLP-1 RA/Insulin)
High
GLP-1 (Not listed above), MTF, SGLT-2i, SU, TZD
Intermediate
DPP-4i

Achievement and maintenance of weight management

Very High
Semglutide, Tirzepatide
High
Dulaglutide, Liraglutide
Intermediate
SGLT2i, GLP-1 RA (not listed above)
Neutral
DPP-4i, Metformin

General Device Principles

7.8 Consider early initiation, including at diagnosis, of CGM, CSII, and AID depending on a person's or caregiver's needs and preferences. **C**

7.8a There should be no requirement of C-peptide level, **B** presence of islet autoantibodies, **B** or duration of insulin treatment **C** before initiation of CSII or AID.

General Device Principles

7.9 Standardized reports for all CGM, CSII, AID, and connected insulin devices with minimum of single-page report, such as AGP and weekly summary, should be available and utilized. Options for daily and weekly reports and raw data should be available. **E**

Insulin Delivery (Pumps and Automated Delivery Systems)

7.25a AID systems are the preferred insulin delivery method over multiple daily injections (MDI), CSII, and sensor- augmented pump in people with T1D, **A** adults with T2D, **A** children and adolescents with T2D, **E** and other forms of insulin-deficient diabetes. **B–E**

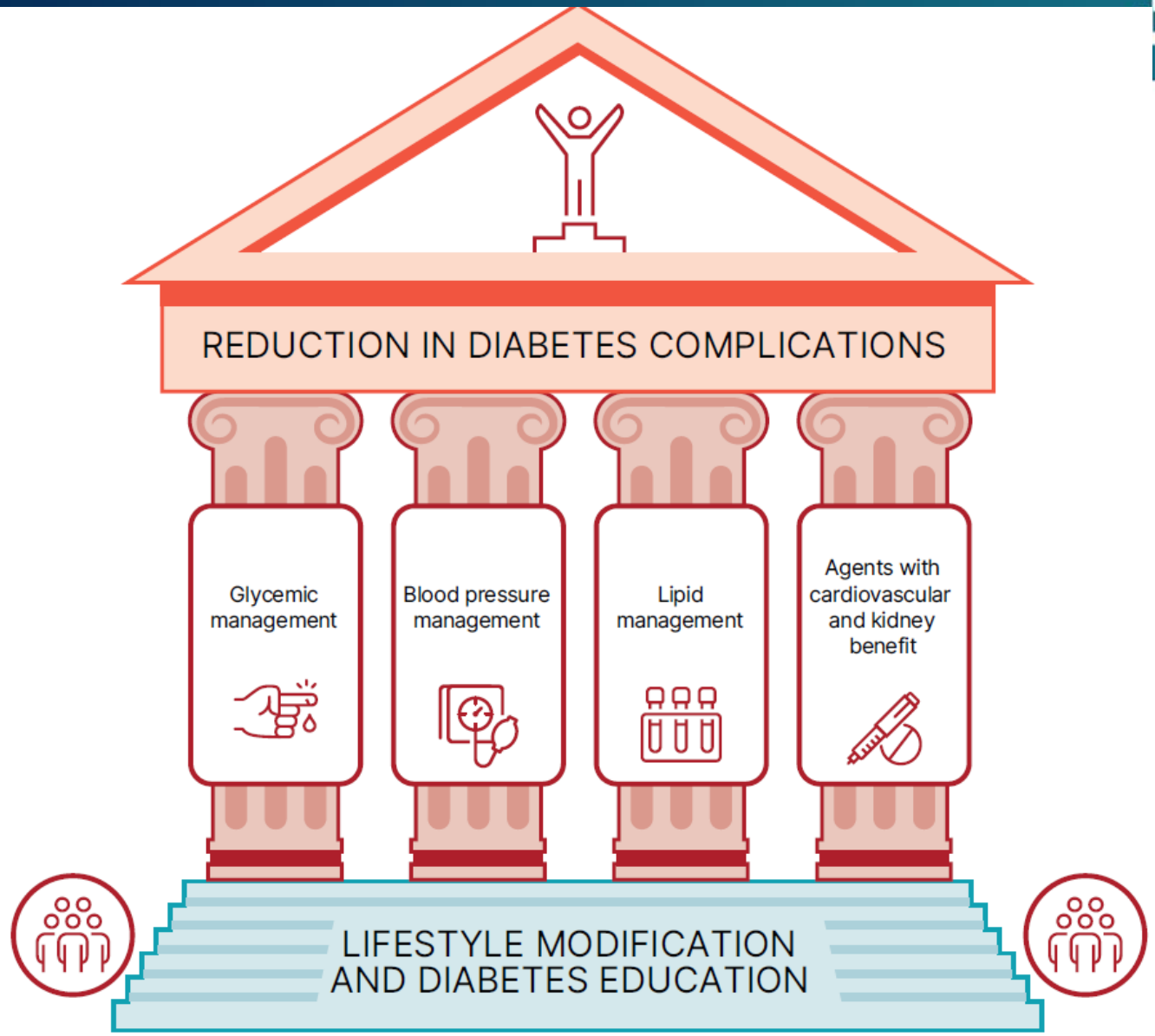
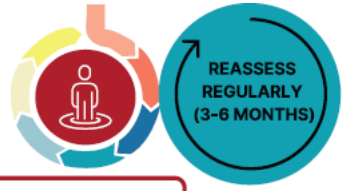


Figure 10.1—Multifactorial approach to reduction in risk of diabetes complications.

Figure 10.1
Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes - 2026
Diabetes Care 2026;49(Suppl. 1):S216-S245

Recommendations for the treatment of confirmed hypertension in nonpregnant people with diabetes



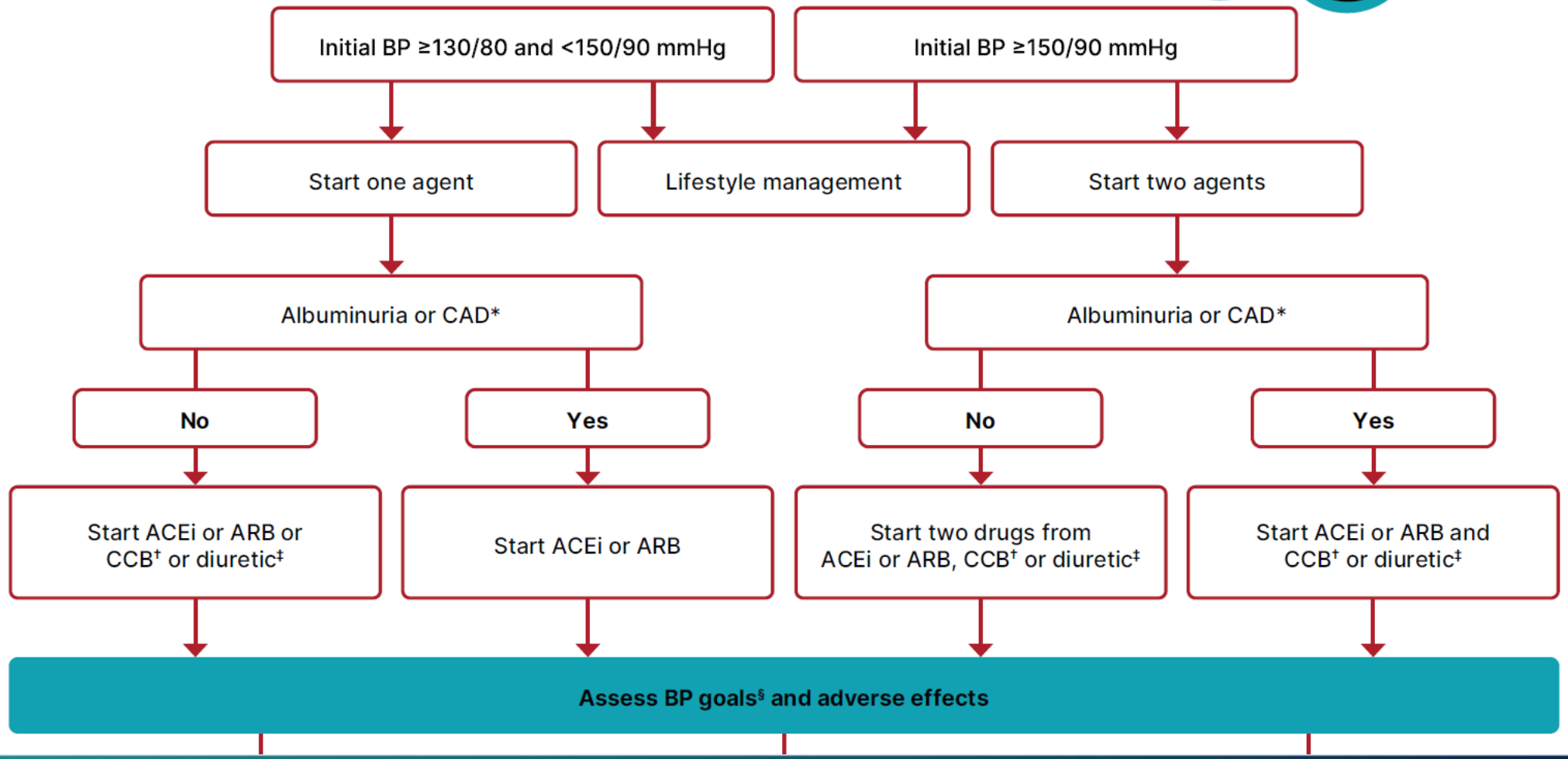


Figure 10.2
Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes - 2026 *Diabetes Care* 2026;49(Suppl. 1):S216-S245

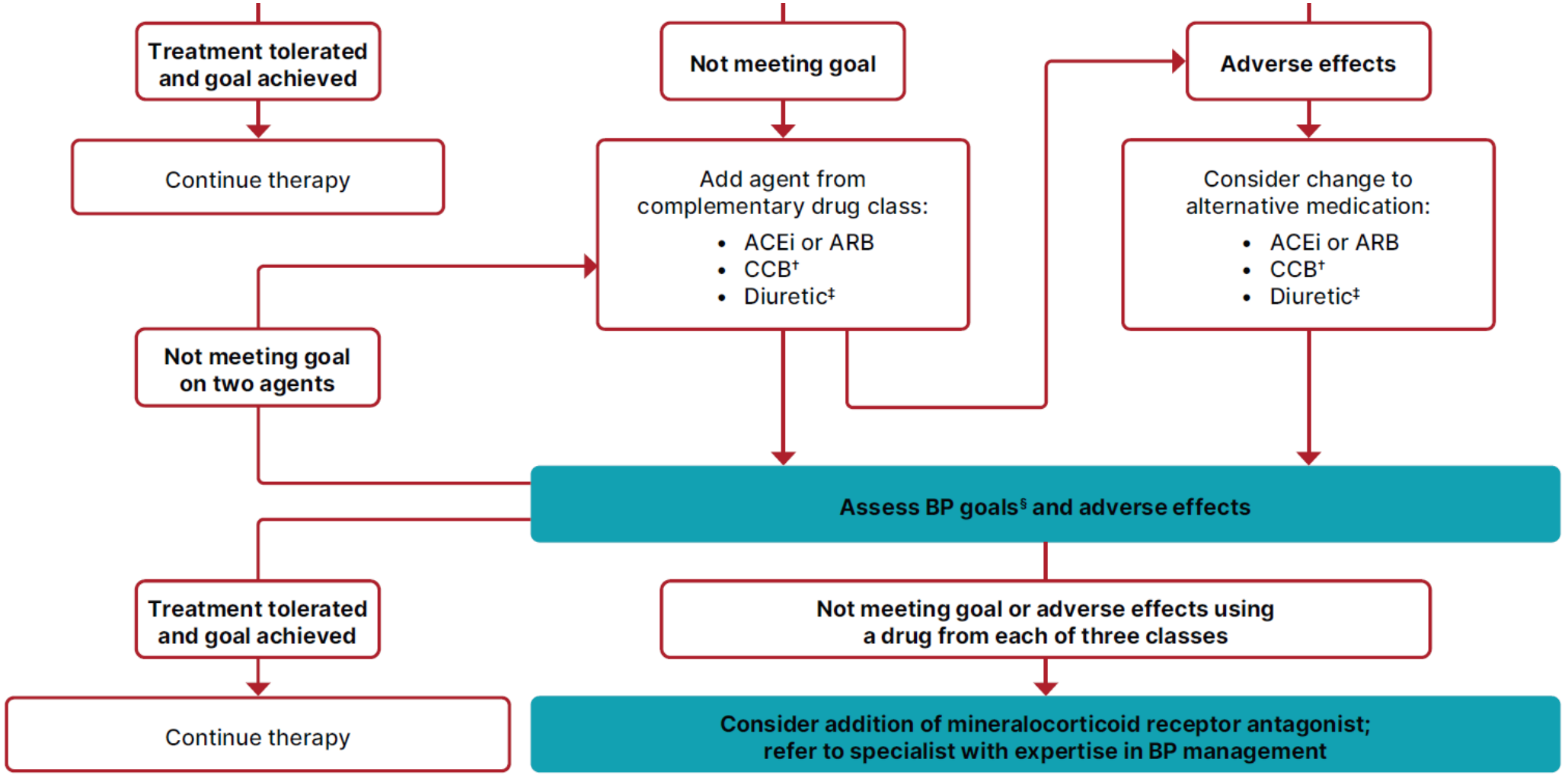


Figure 10.2 (continued) Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes - 2026 Diabetes Care
2026;49(Suppl. 1):S216-S245

Blood Pressure Management – Treatment Goals

10.4 If it can be safely attained, on-treatment Bp goal is <130/80 mmHg; SBP goal <120 mmHg should be encouraged in individuals with high CV or kidney risk. **A**

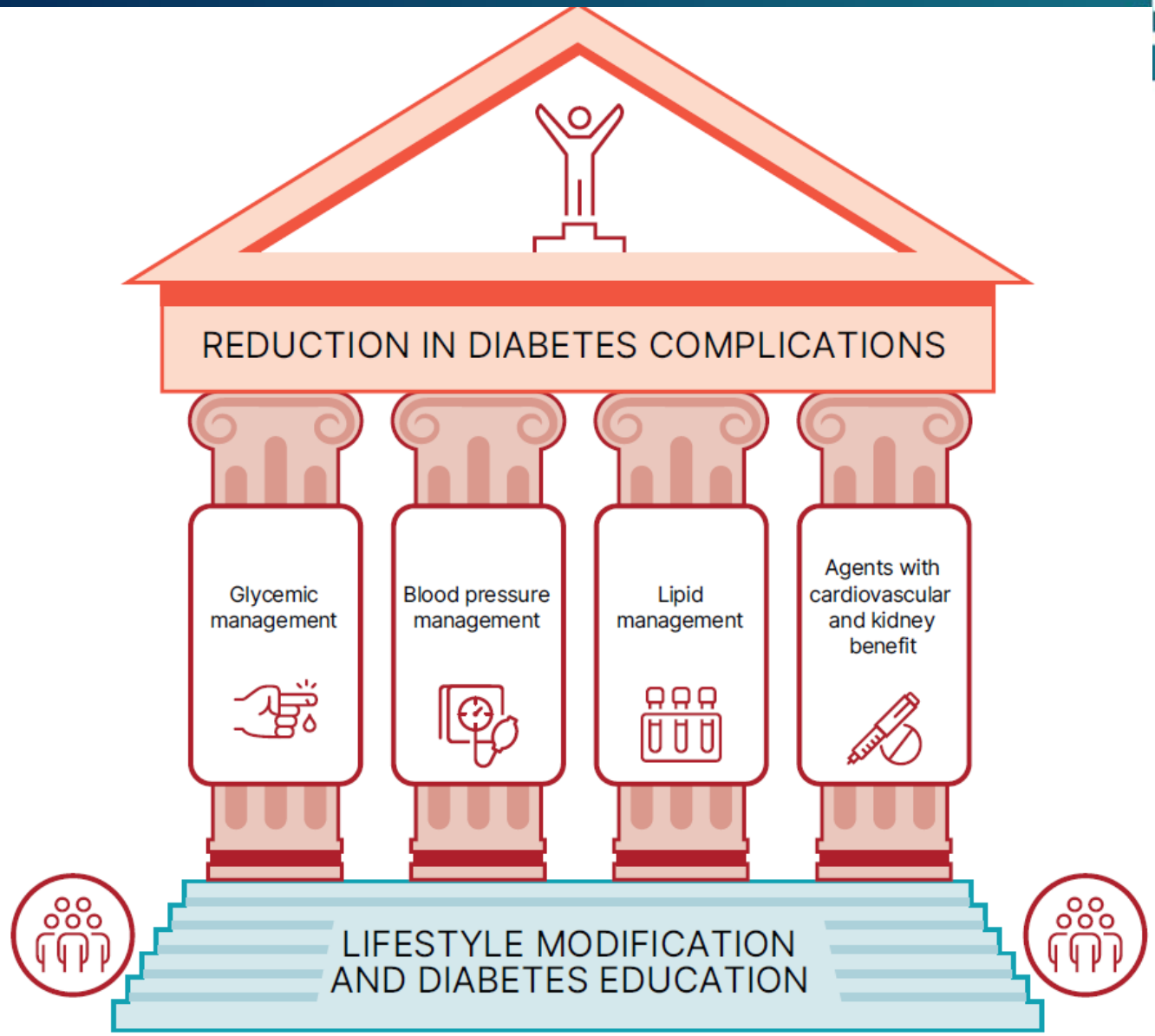


Figure 10.1—Multifactorial approach to reduction in risk of diabetes complications.

Figure 10.1
Cardiovascular Disease and Risk Management: *Standards of Care in Diabetes - 2026 Diabetes Care* 2026;49(Suppl. 1):S216-S245

Lipid Management

- Age 40-75 y + DM + high CV risk →high intensity statin to
  - 1. ↓ LDL by >50% and
  - 2. target LDL <70 mg/dL
- If not at goal, add ezetimibe or PCSK9 inhibitor to maximum tolerated statin

- Age 40-75 y + DM + CAD → high intensity statin to
  - 1. ↓ LDL by >50% and
  - 2. target LDL <55 mg/dL
- If not at goal, add ezetimibe or PCSK9 inhibitor to maximum tolerated statin

Lipid Management

- May not be statin intolerant: switching to another agent, starting at a lower dose or alternate day therapy regimen.
- Intolerance to statin therapy: Bempedoic acid

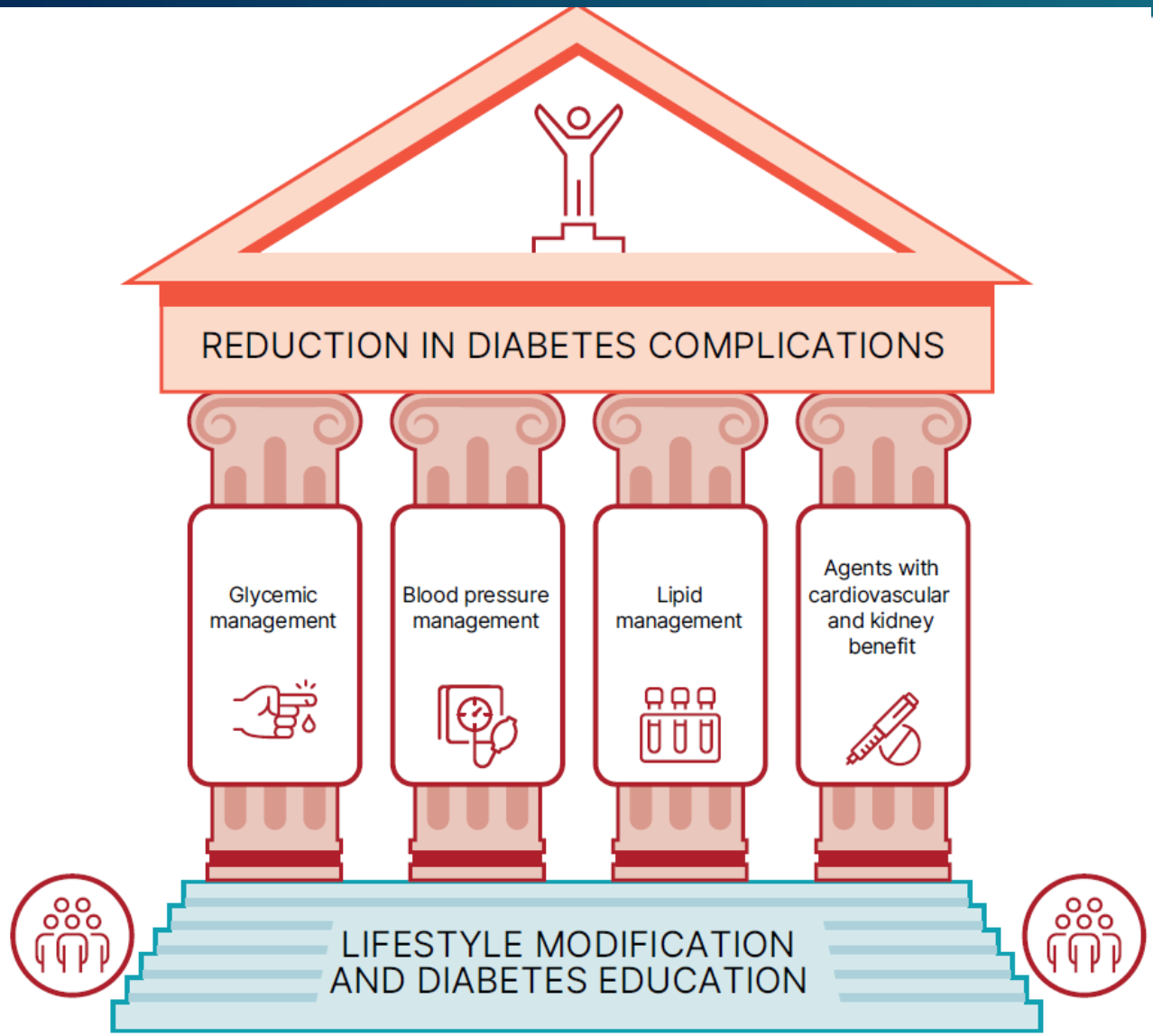


Figure 10.1—Multifactorial approach to reduction in risk of diabetes complications.

Figure 10.1
Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes –
2026 Diabetes Care 2026;49(Suppl. 1):S216-S245

Cardiovascular Disease – Treatment

10.44c In individuals with T2D and asymptomatic (stage B) heart failure or with high risk of or established CV disease, treatment with SGLT2i with proven heart failure prevention benefit **A** or a GLP-1 RA with heart failure prevention benefit **B** is recommended to reduce risk of hospitalization for heart failure.

Cardiovascular Disease – Treatment

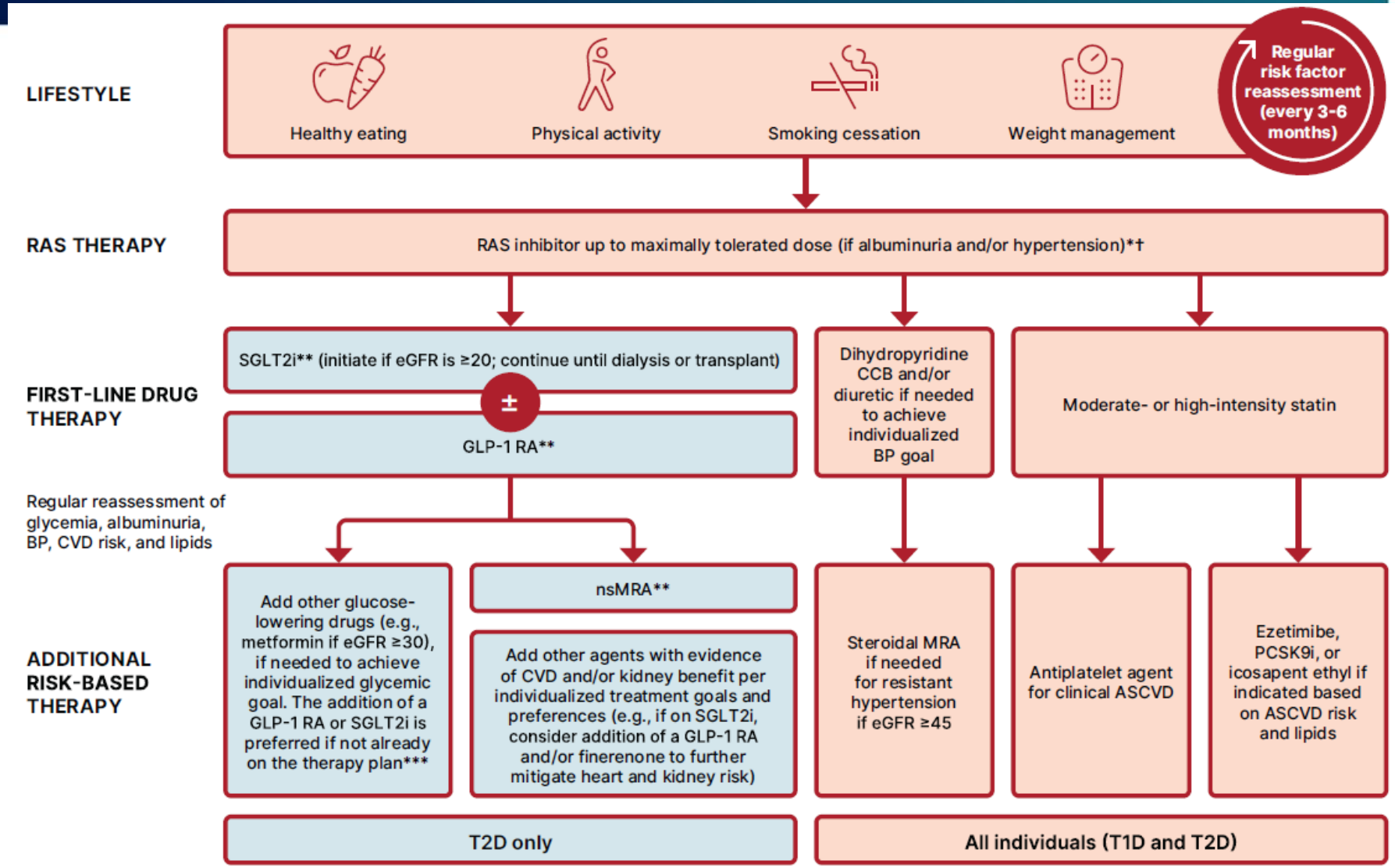
10.44d In adults with type 2 diabetes, obesity, and symptomatic heart failure with preserved ejection fraction (HFpEF), the treatment plan should include a dual GIP/GLP-1 RA **A** or a GLP-1 RA **B** with demonstrated benefit for reduction in heart failure events.

Cardiovascular Disease – Treatment

10.44e In adults with type 2 diabetes, obesity, and symptomatic heart failure with preserved ejection fraction (HFpEF), the treatment plan should include a dual GIP/GLP-1 RA or a GLP-1 RA with demonstrated benefit for reduction in heart failure symptoms. **A**

Cardiovascular Disease – Treatment

10.44h In individuals with diabetes and symptomatic stage C heart failure with EF >40%, nonsteroidal MRA with proven benefit in reducing worsening HF events is recommended. A Nonsteroidal MRA should not be used with MRA.



*The majority of participants in SGLT2i, GLP-1 RA and nsMRA kidney outcome trials were receiving background optimized RAS inhibitor therapy.
**With demonstrated benefit in this population
***Glucose-lowering efficacy of GLP-1 RAs is preserved at low eGFR; glucose-lowering efficacy of SGLT2i is diminished at lower eGFR.

Figure 11.2
Chronic Kidney Disease and Risk Management: *Standards of Care in Diabetes – 2026 Diabetes Care* 2026;49(Suppl. 1):S246-S260

Treatment of Obesity in T1D

8.29 Apply obesity management strategies used in general adult population, including GLP-1 RA-based therapy **B** and metabolic surgery, **C** to adults with T1D who have obesity (BMI ≥30.0 kg/m², or ≥27.5 kg/m² in Asian American individuals). Shared decision-making should inform individualized care.

Autoimmune Diseases

4.6 Screen people with T1D for autoimmune thyroid disease soon after diagnosis and thereafter at repeated intervals if clinically indicated. **B**

4.7 Adults with T1D should be screened for celiac disease in presence of GI symptoms, signs, lab manifestations, or clinical suspicion suggestive of celiac disease. **B**

Bone Health

4.11 To reduce risk of falls and fractures, glycemic management goals should be individualized for people with diabetes at a higher risk of fracture. **C** Prioritize use of glucose-lowering medications that are associated with low risk for hypoglycemia to avoid falls. **B**

Bone Health

4.12 Advise people with diabetes on intake of calcium (1,000–1,200 mg/day) and vitamin D to ensure it meets RDA for those at risk for fracture, either through food or supplemental means. **B**

Bone Health

4.13a Consider osteoporosis drug therapy in older adults with diabetes who are at increased risk of fracture, including those with low BMD (T-score ≤−2.5), history of fragility fracture, or elevated FRAX score (≥3% for hip fracture or ≥20% for major osteoporotic fracture). **B**

Bone Health

4.13b Treatment may be considered for adults with diabetes with a T-score between −2.0 and −2.5 in the presence of additional risk factors for fracture. **C**

Diagnostic algorithm for the prevention of cirrhosis in people with metabolic dysfunction–associated steatotic liver disease (MASLD)

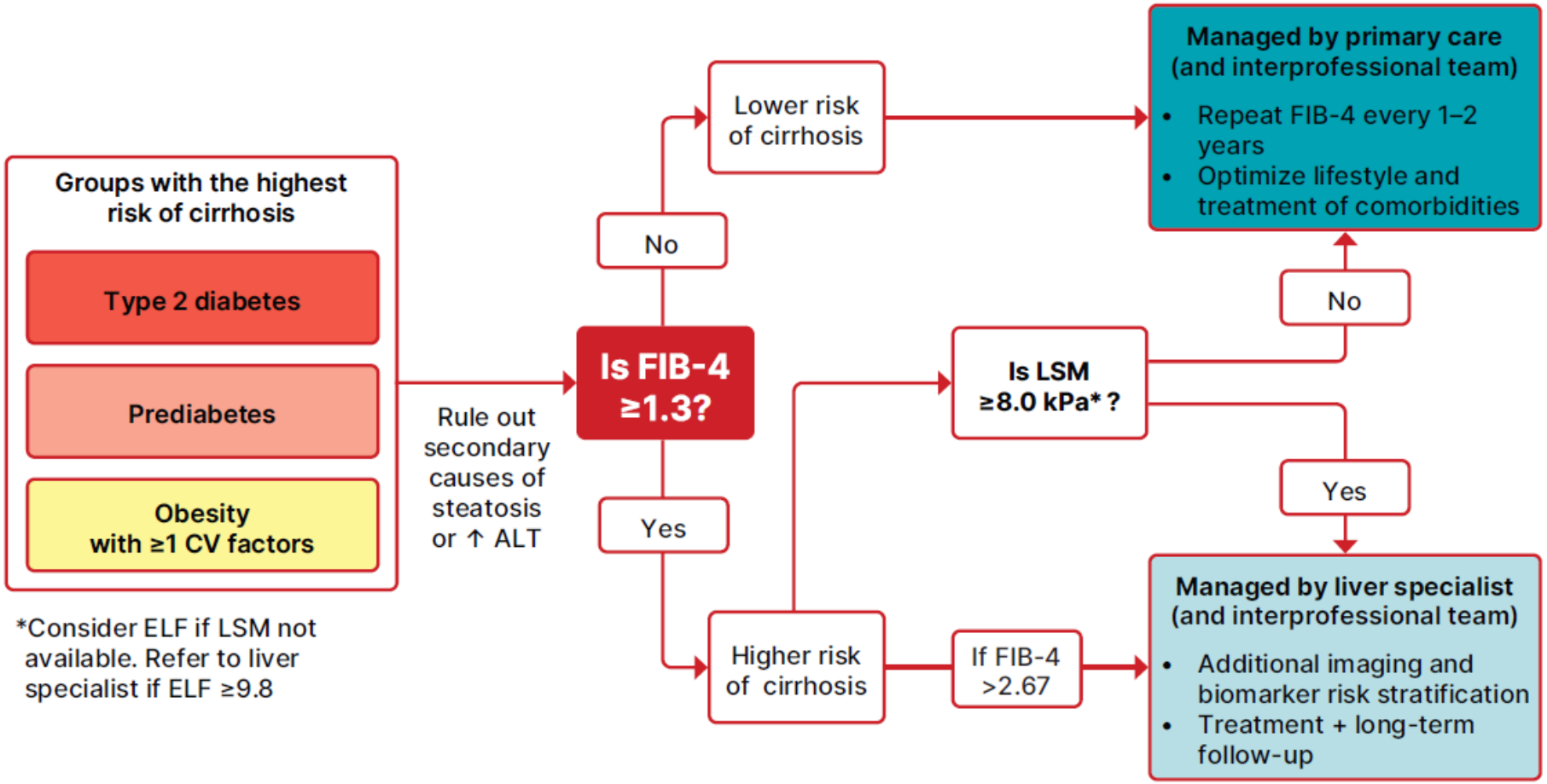
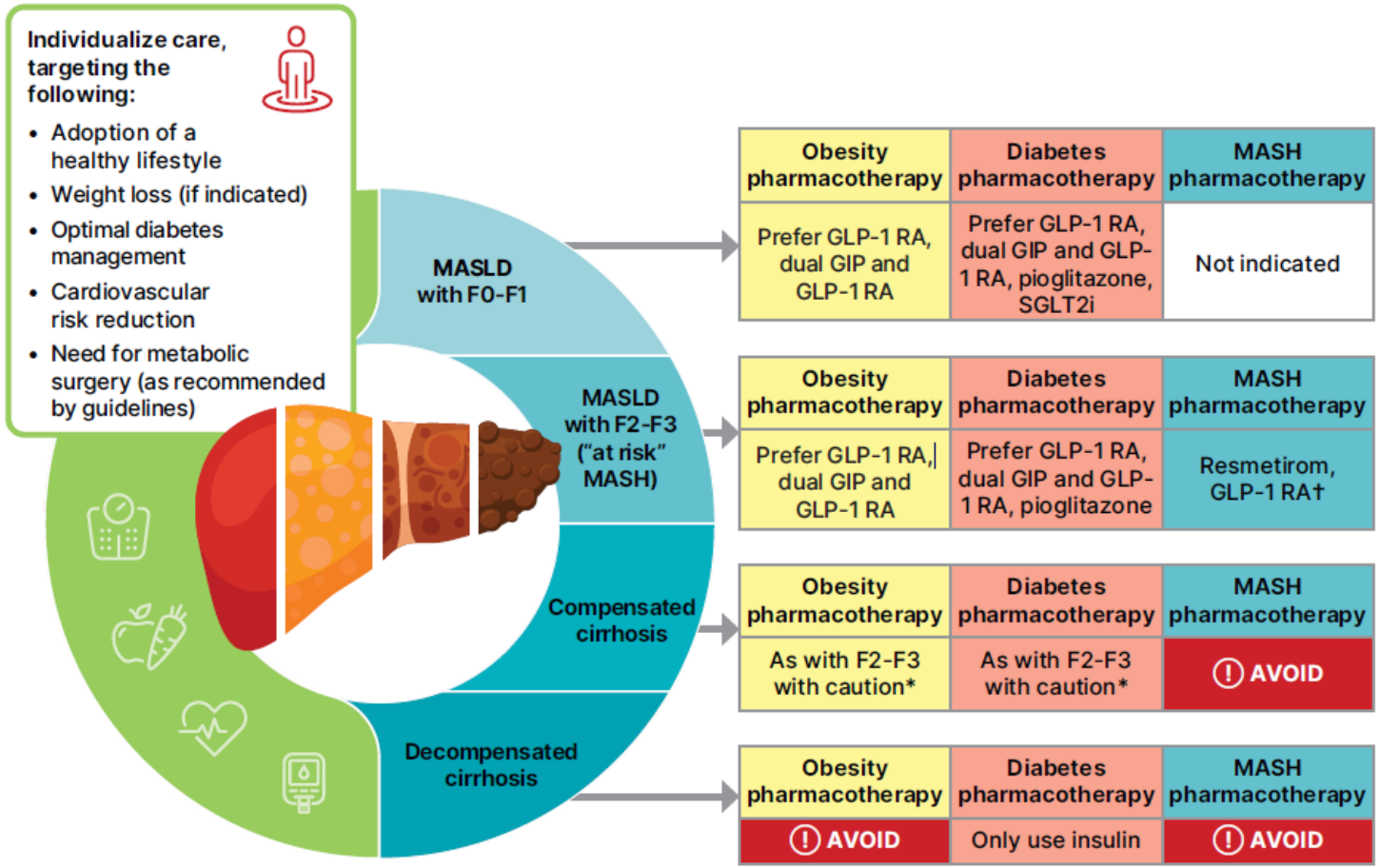


Figure 4.2
Comprehensive Medical Evaluation and Assessment of Comorbidities: *Standards of Care in Diabetes – 2026*. *Diabetes Care* 2026;49(Suppl. 1):S61-S88

Figure 4.2—Diagnostic algorithm for risk stratification and the prevention of cirrhosis in individuals with metabolic dysfunction-associated steatotic liver disease (MASLD). CV, cardiovascular; ELF, enhanced liver fibrosis test; FIB-4, fibrosis-4 index; LSM, liver stiffness measurement, as measured by vibration-controlled transient elastography. *In the absence of LSM, consider ELF a diagnostic alternative. If ELF ≥9.8, an individual is at high risk of metabolic dysfunction-associated steatohepatitis with advanced liver fibrosis (≥F3–F4) and should be referred to a liver specialist.

Metabolic dysfunction–associated steatotic liver disease (MASLD) treatment algorithm



† Only semaglutide among GLP-1 RAs has been approved by the FDA for treatment of MASH.
* Individualized care and close monitoring needed in compensated cirrhosis given limited safety data available.

Figure 4.3—Metabolic dysfunction-associated steatotic liver disease (MASLD) treatment algorithm. F0-F1, no to minimal fibrosis; F2-F3, moderate fibrosis; F4, cirrhosis; GIP, glucose-dependent insulinotropic polypeptide; GLP-1 RA, glucagon-like peptide 1 receptor agonist; MASH, metabolic dysfunction-associated steatohepatitis; SGLT2i, sodium–glucose cotransporter 2 inhibitor.

Figure 4.3
Comprehensive Medical Evaluation and Assessment of Comorbidities:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S61-S88

Dental Care

4.15 People with diabetes should be referred for a dental exam at least once per year. **E**

Sexual Dysfunction

- In postmenopausal women with diabetes or prediabetes, screen for symptoms and/or signs of genitourinary syndrome of menopause, including vaginal dryness and dyspareunia. B

Hypoglycemia in Older Adults

13.5 Recommend continuous glucose monitoring (CGM) for older adults with T1D **A** and T2D on insulin therapy **B** to improve glycemic outcomes, reduce hypoglycemia, and reduce treatment burden.

Older Adults

13.9 On-treatment Bp goal for most older adults with diabetes is <130/80 mmHg when it can be achieved safely, **A** and more a relaxed blood pressure goal (e.g., <140/90 mmHg) may be used for people with poor health, limited life expectancy, or high risk for adverse effects of hypertensive therapy. **E**

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Older Adults

13.11a Recommend healthful eating with adequate protein intake (at least 0.8 g/kg body weight/day) for older adults with diabetes to maintain and potentially higher, individualized amounts to regain lean body mass and function. **B**

Religious Fasting

5.32 Use updated International Diabetes Federation along with Diabetes and Ramadan International Alliance comprehensive prefasting risk assessment to generate risk score for safety of religious fasting. Provide fasting-focused education to minimize risks. **B**

5.33 Assess and optimize treatment plan, dose, and timing for people with diabetes well in advance of religious fasting to reduce risk of hypoglycemia, dehydration, hyperglycemia, and/or ketoacidosis. **B**

Table 5.3—Elements for risk calculation and suggested risk score for people with diabetes who seek to fast during Ramadan

Fasting risk element	Risk score
1. Pregnancy with any type of diabetes	
• Yes	6.5
2. Diabetes type	
• Type 1 diabetes or LADA	1
• Type 2 diabetes or any other type of diabetes	0
3. Duration of diabetes (years)	
• >20 years	1
• 10–20 years	0.5
• <10 years	0
4. Type of diabetes treatment (select all that are relevant)	
• Multiple daily premixed insulin injections	2
• Once-daily premixed insulin	1.5
• Open-loop insulin pump	1.5
• Automated insulin delivery system	1
• Standard basal insulin (NPH, detemir, or glargine 100)	1
• Ultra-long-acting basal insulin (glargine 300 or degludec)	0.75
• Short-acting insulin	0.75
• Glibenclamide or glipizide	0.75
• Modern sulfonylurea (gliclazide, gliclazide MR, glimepride) or repeglanide	0.5
• ≥2 glucose-lowering medications excluding insulin or sulfonylurea	0.25
• Nutrition modification only or monotherapy (excluding insulin or sulfonylurea)	0
5. Presence of hypoglycemia	
• Impaired hypoglycemia awareness	6.5
• Severe* hypoglycemia during last 4 weeks	5
• Hypoglycemia more than once daily	4
• 6–7 episodes of hypoglycemia/week	3
• 3–5 episodes of hypoglycemia/week	2
• 1–2 episodes of hypoglycemia/week	1
• Hypoglycemia <1 time per week	0.5
• No hypoglycemia in last 4 weeks	0
6. Level of A1C	
• >9% (>75 mmol/mol)	1
• 7.5–9% (58–75 mmol/mol)	0.5
• <7.5% (<58 mmol/mol)	0
7. Glucose monitoring	
• Not done	2
• Done suboptimally	1
• Done as indicated	0
• Any type of CGM	–0.5
8. Hyperglycemic emergencies	
• DKA or HHS in the last month	3.5
• DKA or HHS in last 2–3 months	2
• DKA or HHS in last 4–6 months	1
• No DKA or HHS in last 6 months	0
9. Macrovascular** complications	
• Unstable macrovascular disease	6.5
• Stable macrovascular disease	2
• No macrovascular disease	0
10. Microvascular complications	
a. Nephropathy	
• eGFR <30 mL/min	6.5
• eGFR 30–45 mL/min	4
• eGFR 45–60 mL/min	2
• eGFR >60 mL/min	0
b. Neuropathy, foot complications, or diabetic retinopathy	
• 3 microvascular complications	3
• 2 microvascular complications	2
• 1 microvascular complication	1
• 0 microvascular complications	0

Continued on p. S102

Table 5.3
Facilitating Positive Heath Behaviors and Well-being to Improve Health Outcomes: *Standards of Care in Diabetes - 2026*. *Diabetes Care* 2026;49(Suppl. 1):S89-S131

Table 5.3—Continued

Fasting risk element	Risk score
11. Cognitive function, frailty, and age	
• Impaired cognitive function	6.5
• Advanced frailty	6.5
• Mild to moderate frailty	4
• Age >70 years with no home support	1
• Normal cognitive function and no frailty	0
12. Physical labor	
• High intensity	4
• Moderate intensity	2
• Low intensity	0
13. Fasting-focused education	
• Yes	0
• No	1
14. Fasting hours	
• ≥16 h	1
• <16 h	0

Based on risk scoring, people with diabetes can be categorized as having:

- Score 0–3.0: low risk, fasting is probably safe
- Score 3.5–6.0: moderate risk, fasting safety is uncertain
- Score >6.0: high risk, fasting is probably unsafe

AID, automated insulin delivery; CGM, continuous glucose monitoring; DKA, diabetic ketoacidosis; eGFR, estimated glomerular filtration rate; HHS, hyperglycemic hyperosmolar state; LADA, latent autoimmune diabetes in adults (type 1 diabetes). *Hypoglycemia requiring assistance for treatment. **Macrovascular disease includes cardiac, cerebral, or peripheral. Adapted from Hassanein et al. (224).

Table 5.3
Facilitating Positive Heath Behaviors and Well-being to Improve Health Outcomes: *Standards of Care in Diabetes - 2026*. *Diabetes Care* 2026;49(Suppl. 1):S89-S131

Diabetes Induced by Systemic Anti-Cancer Therapy

2.19 People starting cancer treatment with ICIs (e.g., nivolumab, pembrolizumab, avelumab), PI3 Kinase α inhibitors (e.g., alpelisib, inavolisib), or mTOR inhibitors (e.g., everolimus), should be educated regarding risks, symptoms, and signs of hyperglycemia and hyperglycemic crises. **E**

Diabetes Induced by Systemic Anti-Cancer Therapy

2.20 In people treated with ICIs, fasting or random plasma glucose should be tested before initiating treatment, during each visit, or if symptoms and signs of hyperglycemia develop during or after treatment cessation. E

Diabetes Induced by Systemic Anti-Cancer Therapy

2.21 In people treated with PI3Kα inhibitors, fasting or random plasma glucose and A1C should be tested before initiating treatment, and random plasma glucose should be tested weekly for the first 2 weeks of treatment and then every 4 weeks during treatment. C Consider testing A1C every 3 months during treatment. E

Diabetes Induced by Systemic Anti-Cancer Therapy

2.22 In people treated with mTOR inhibitors, fasting or random plasma glucose should be tested before starting and at each visit throughout the duration of treatment. Consider testing A1C every 3 months during treatment. C

Posttranslplantation Diabetes Mellitus

2.26 After organ transplantation, screening for hyperglycemia should be done. Formal diagnosis of PTDM is best made once the individual is stable on immunosuppressive plan and in the absence of acute infection. **B**

2.27 OGTT is preferred test to make a diagnosis of PTDM. **B**

Posttranslplantation Diabetes Mellitus

2.28 Immunosuppressive plans shown to provide best outcomes for individuals and graft survival should be used, irrespective of PTDM risk. **E**

Questions?

LOUISIANA DEPARTMENT OF HEALTH

Project ECHO®

Thank you, Dr. Bhalla!

Wrap-Up & Announcements

Wrap-Up & Announcements

- Enter your information for attendance
- Complete survey for CEUs
- Next Session: February 26, 2026 from 12:00 p.m. to 1:00 p.m.
- Next Didactic Presentation: Lifestyle Medicine for Diabetes Management and Prevention
- Send questions to wellahead.projectecho@la.gov
- Interested in presenting a case? Email wellahead.projectecho@la.gov

THANK YOU

Next Session: February 26, 2026 from 12:00 p.m. to 1:00 p.m.
Lifestyle Medicine for Diabetes Management and Prevention
by Christine Castille, FNP-C, BC-ADM, CDCES

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http://wellaheadla.com

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