



Diabetes Nutrition Therapy: Research, Recommendations, and Real World: The 2025 Outstanding Educator in Diabetes Award Lecture

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Diabetes, Obesity, and Cardiometabolic CARE 2026;1:176–183 | <https://doi.org/10.2337/doci25-0002>

This article is adapted from the address I delivered as the recipient of the American Diabetes Association 2025 Outstanding Educator in Diabetes Award. The lecture outlined my work over the last 40 years as a diabetes nutrition educator. I reviewed my contributions to the development of evidence-based nutrition guidelines and, more recently, embedding diabetes nutrition services in primary care. I would like to begin by thanking the American Diabetes Association (ADA) for this award. The ADA has had a long tradition of recognizing health care professionals (HCPs) who have contributed to the field of diabetes education, and I feel honored to join this distinguished group.

How My Journey as a Diabetes Nutrition Educator Began

I attended Washington State University (WSU), a land grant college surrounded by wheat fields, more than 300 miles from the greater Seattle area, where I was born and raised. I earned a degree in clinical dietetics that combined my love of science and the culinary arts. I have also been lucky to share my 40-year professional journey with my identical twin sister, Barbara Grant, a registered dietitian nutritionist (RDN) working in the field of oncology. Washington State University provided both of us with a board curriculum, encompassing both clinical dietetics and institutional food service management.

Upon completing my education and dietetic internship I secured a position as an inpatient dietitian at a hospital in the greater Seattle area. I soon realized that I really enjoyed providing nutrition education and counseling to hospitalized patients, particularly those with chronic health conditions such as diabetes. Unfortunately, a vast majority of the medical nutrition therapy (MNT) sessions I provided were ordered

only a few minutes before the patient was discharged from the hospital. All too often, it seemed the nutrition education session was delivered to a patient sitting in a wheelchair as the family was waiting to wheel them to their car. This strategy was definitely not conducive to an individualized patient-centered education session. After I was promoted to manage the clinical inpatient dietitian team, I worked with the hospital administration to create the first position for an outpatient dietitian and a billing/reimbursement structure. This approach allowed the patient and family/caregivers to return for an individualized session where their health goals could be better met.

After nearly a decade of inpatient work, I transitioned to an outpatient dietitian position at another large urban hospital. On my first day of work I was told that I not only would be delivering MNT but also several times a month would be teaching diabetes self-management education and support (DSMES) classes. It was shared that my first DSMES class would be held later that very day. I was also informed that they did not know where the nutrition class slides and lecture notes were! And so began my journey as an outpatient diabetes nutrition educator. However, it was a pivotal day for me in my career. I learned that it takes a team of health care professionals to assist someone with diabetes or at risk of diabetes to navigate management of this chronic disease. My new DSMES team member was Christina Peltó, registered nurse (RN). She was one of the first HCPs in the nation to achieve certification as a certified diabetes educator (CDE). With her mentorship I acquired the knowledge and expertise required to successfully obtain the multidisciplinary CDE certification. Throughout my long career, I have followed Chris's example and have served as a mentor to other HCPs pursuing the credential now known as the certified diabetes care and education specialist (CDCES). It should

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The 2025 Outstanding Educator in Diabetes Award Lecture was presented at the American Diabetes Association's 85th Scientific Sessions, Chicago, IL, on 21 June 2025.

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also be noted that the recommendation of the ADA “Standards of Care in Diabetes” (1) is, as for many years, that people with diabetes can benefit from a coordinated interprofessional team that may include but is not limited to RDNs; diabetes care and educational specialists and advanced practice clinicians, e.g., CDCES or Board Certified–Advanced Diabetes Management (BC-ADM); RNs; pharmacists; and primary care providers (1,2).

What Can I Eat When I Have Diabetes?

In my work as a CDCES delivering diabetes and nutrition education to groups and individuals it soon became apparent that one of my patients’ most commonly asked questions was, “What can I eat?” As a result, I became very curious about how HCPs learn and stay abreast of evidence-based diabetes nutrition education research and recommendations. In our work as diabetes HCPs it is imperative that we provide our patients with up-to-date and accurate, as well as patient-centered, health information. In addition, as clinicians we bring our clinical expertise and experience, as well as our knowledge of the evidence, to our patient encounters. And to those same encounters our patients bring their life experiences and their knowledge of diabetes self-care. And, to complicate matters, the average person makes hundreds of decisions on a daily basis. Researchers in this field of study estimate that >200 of those decisions are about food, concerning what, when, and how much to eat (3). Hopefully decisions about diabetes and nutrition treatment and management are based on science, not myth, hype or TikTok videos, or social media influencers. It is where all of this intersects that the magic happens—something known as shared decision-making (4). Placing the person with diabetes and their family or support system at the center of the care model ensures that the individual’s needs and goals guide decision-making (5). A person-centered approach is another key tenant of the team management of diabetes (1,6) (Fig. 1).

Realities of Diabetes Nutrition Research

When my husband’s job took our family to Arizona in the early 1990s, I was hired by an endocrinology practice that also conducted clinical research trials. I learned firsthand that pharmaceutical trials had dramatically different numbers of participants and study durations. How I envied my physician colleagues who could base treatment decisions and recommendations on multicenter randomized controlled trials that included thousands of participants, conducted over several years. The reality of diabetes nutrition research is that studies typically include <50 participants, with durations of 12–24 weeks—rarely do they last a year. Consider the complexity and cost of a nutrition trial, that requires preparing and providing meals and snacks during the intervention, compared with a pharmaceutical trial where the intervention is a pill or placebo.

As a registered dietitian or diabetes clinician where do you look for diabetes nutrition therapy research to guide practice and also determine whether it is effective? I learned that I can look to one of my professional organizations for evidence-based diabetes nutrition recommendations, specifically, the Academy of Nutrition and Dietetics (Academy), a professional organization of >50,000 RDNs. When the Academy was looking for volunteers to conduct a rigorous systematic review to update their Evidence Analysis Library for development of nutrition practice guidelines for adults with type 1 and type 2 diabetes, I jumped at the opportunity to volunteer. Marion Franz, MS, RDN, served as chair of the committee. Marion and writing team member Janice MacLeod, MS, RDN, CDCES, also worked tirelessly to submit two manuscripts to a peer-reviewed journal so that this important systematic review could be available to all diabetes HCPs—not just members of the Academy (7,8). My heartfelt thanks go to the Academy for financial support through member dues to fund this important work. I am also grateful to Marion for her mentorship and advocacy of the critical role of the RDN on the diabetes care team.

The ADA also strives to review the literature on the topic of diabetes nutrition therapy to guide practice recommendations. I was asked by the ADA to serve as the co-chair of the 2014 and 2019 diabetes nutrition therapy writing group committees convened by the ADA (9,10)—the 2014 position statement with co-chair Jackie Boucher, MS, RDN, and 2019 consensus report with co-chair William Yancy, MD. A recent PubMed search revealed that there have been >3,700 citations attributed to these two publications. It should be noted that 2014/2019 writing team member Patti Urbanski, MEd, RDN, CDCES, the most recent ADA President of Health Care & Education, along with Dr. Yancy is serving on the writing group convened to update the 2019 ADA nutrition therapy consensus report (10), with a completion date in 2026.

Findings from the nutrition therapy consensus report (10) are incorporated into the ADA “Standards of Care in Diabetes” to guide practice recommendations, the majority found in section 5 (11). As a reminder, the ADA’s “Standards of Care in Diabetes” is the “go to” resource for diabetes management. It is published annually in January and is available at no charge online for HCPs to use in providing care to people with diabetes (https://diabetesjournals.org/care/issue/49/Supplement_1).

Regarding other professional diabetes nutrition therapy resources, I have served as the co-editor of the last three editions of the *American Diabetes Association Guide to Nutrition Therapy for Diabetes*. This resource is part of the ADA professional book series. I am delighted to be working on the 4th edition (12) with Maureen Chomko, RDN, CDCES, a rising star in the diabetes nutrition world. The guide includes many diabetes nutrition therapy topics, as individuals in our care often have other

Decision cycle for person-centered glycemc management in type 2 diabetes

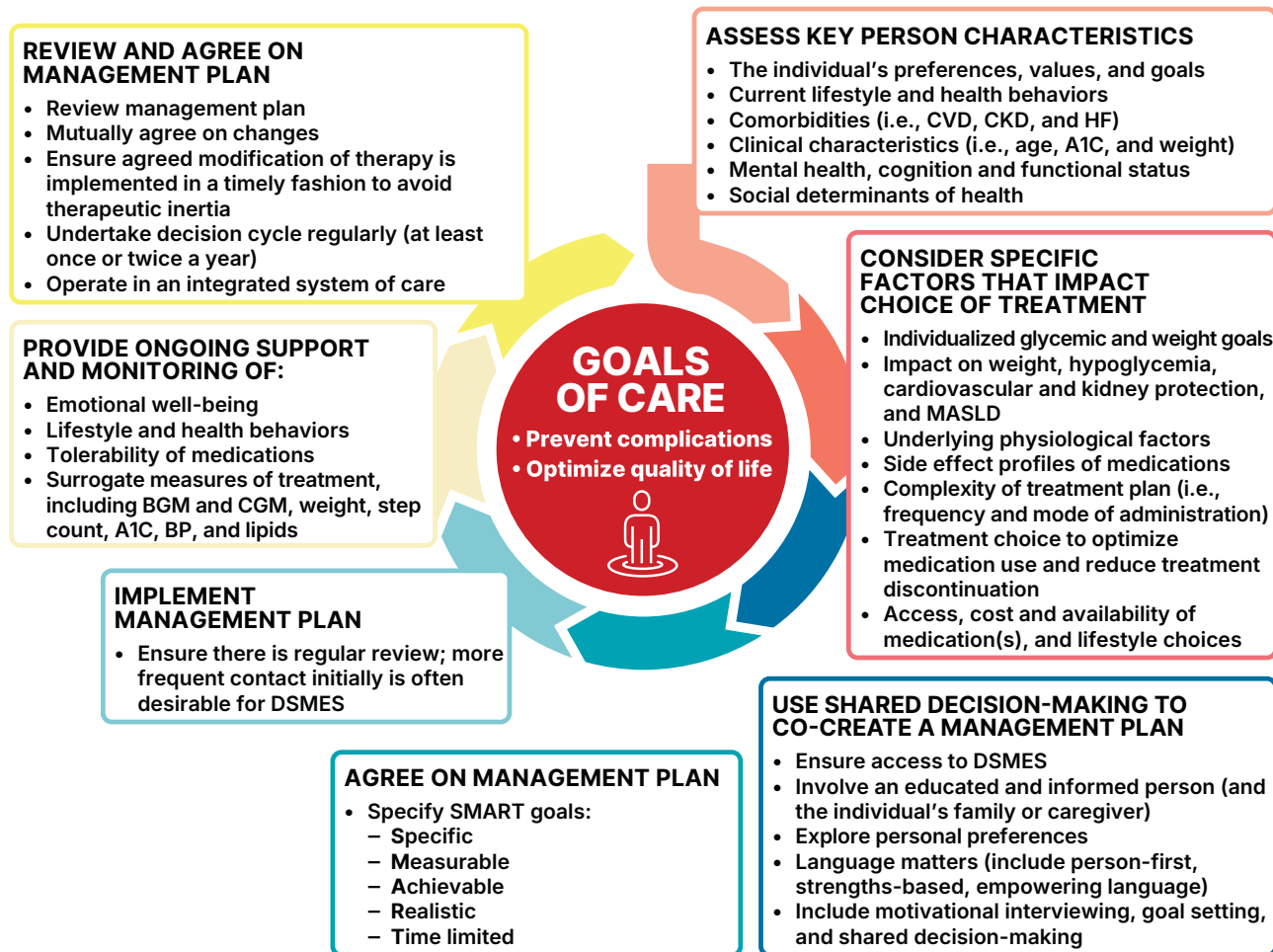


FIGURE 1 Decision cycle for person-centered glycemc management in type 2 diabetes. BGM, blood glucose monitoring; BP, blood pressure; CGM, continuous glucose monitoring; CKD, chronic kidney disease; CVD, cardiovascular disease; DSMES, diabetes self-management education and support; HF, heart failure; MASLD, metabolic dysfunction-associated steatotic liver disease. Originally published in Davies et al. (6); reprinted from ADA "Standards of Care in Diabetes—2026" (1).

comorbidities or issues or age-related nutritional concerns. The chapter authors have conducted a deep dive into their topics to not only provide a review of the literature but also share clinical practice recommendations.

Diabetes Nutrition Therapy: What's the Evidence?

Similar to DSMES, MNT should be provided at diagnosis of diabetes and throughout the lifespan (7,11,13). Systematic reviews and meta-analyses on the effectiveness of MNT delivered by the RDN reveal the following: 1) at 3–12 months, reported decreases from baseline hemoglobin A_{1c} (A1C) levels of 0.47% in comparison with levels where dietary advice was delivered by other HCPs (14) and 2) at 6–12 months, reported decreases from baseline in A1C of 0.45% in comparison with levels where dietary

advice was delivered by physicians and registered nurses (15).

Studies have demonstrated that ongoing RDN-provided follow-up encounters ranging from three to six sessions, with a minimum of one follow-up session annually, can be helpful in maintaining glycemc improvements (7). During this time, it can be determined whether target goals can be achieved with implementation of MNT in combination with physical activity or whether medication(s) will be needed in combination with MNT. In addition, MNT helps prevent, delay, or treat other comorbidities commonly found with diabetes (7,16). Benefits have not been reported from all studies of cardiovascular disease risk factors, but in some cases this is likely due to a limited opportunity to show benefit, when, for example, lipid and blood pressure levels were already controlled or only mildly abnormal, or where lipid-lowering or

antihypertensive medications are present as cointerventions and mask the effect. MNT provided by an RDN is also cost-effective, and people who have received MNT show improved quality of life and clinical outcomes (17).

Diabetes Nutrition Therapy: It's Part of the Overall Treatment Plan

Nutrition therapy, DSMES, physical activity, and behavioral health recommendations are frequently incorporated into medication algorithms (Fig. 2). Some might argue that health care providers do not need to be educated about diabetes nutrition therapy because RDNs are better trained and positioned to provide nutrition education. However, I would assert that to provide comprehensive care for individuals with chronic health conditions such as diabetes, the entire care team needs to stay up to date on nutrition guidelines, recommendations, and evidence-based practice. I also need to remind HCPs that nutrition therapy does not just have role when prediabetes or diabetes is diagnosed but, rather, is a vital component of chronic disease management (7,10,13). In the case of type 2 diabetes, it is not that “diet and exercise fails”—type 2 diabetes is a progressive condition. Achievement of the individual health goals of the person with diabetes usually requires addition of medication to “diet & exercise” approaches. MNT as well as diabetes self-management education needs to be part of the long-term treatment plan and should be reassessed on an ongoing basis (13). Therefore, I am grateful for this opportunity today to remind diabetes clinicians to make referrals and advocate for these clinically effective services.

What Are the Nutrition Therapy Recommendations for People With Diabetes and Those at Risk?

Nutrient quality, total calories, and metabolic goals are kept in mind with an individualized eating plan—not a cookie-cutter approach or a preprinted diet handout (10). In addition, the focus of eating patterns should be key nutrition principles, such as emphasizing nonstarchy vegetables, minimizing added sugars and refined grains, and choosing whole foods over highly processed foods to the extent possible (10). I should add that people with diabetes want an individualized eating plan or, alternatively, guidance on what to eat.

I would like to take a moment to review some terminology used in nutrition therapy recommendations that may be helpful to keep in mind in working with your patients and clients. I created this nutrition therapy taxonomy to help sort out these commonly used terms (18):

- Eating patterns: Combinations of different foods or food groups. They represent the totality of all foods and beverages consumed and could include some of the following: Mediterranean style, low carbohydrate,

plant-based, and Dietary Approaches to Stop Hypertension (DASH).

- Meal planning approach can be used to plan or organize foods and beverages on a daily basis. Two popular diabetes meal planning approaches include the plate method and carbohydrate counting. Either approach could be used with the eating pattern chosen by the person with diabetes. Other examples of diabetes meal planning approaches could include counting calories or fat grams, glycemic index, and intermittent fasting.
- “Diet,” or as my patients would always say, “die with a t,” is generally viewed as restrictive in nature and not sustainable long-term. More up-to-date terminology is eating plan or meal plan, which is an individualized guide to help plan when, what, and how much to eat on a daily basis.

RDNs in clinical practice work collaboratively as a “guide” or “coach” with patients to create an individualized “eating plan” for their food and beverage intake, using the eating pattern and meal planning approach they chose (18). For example, at an MNT visit, a patient with type 1 diabetes using an insulin pump and glucose sensor may choose a low-carb eating pattern with the carb-counting meal planning approach. Another patient with type 2 diabetes with reduced health numeracy may choose a plant-based eating pattern using the plate method meal planning approach. In either case, the RDN would collaboratively assist them to create an individualized eating plan.

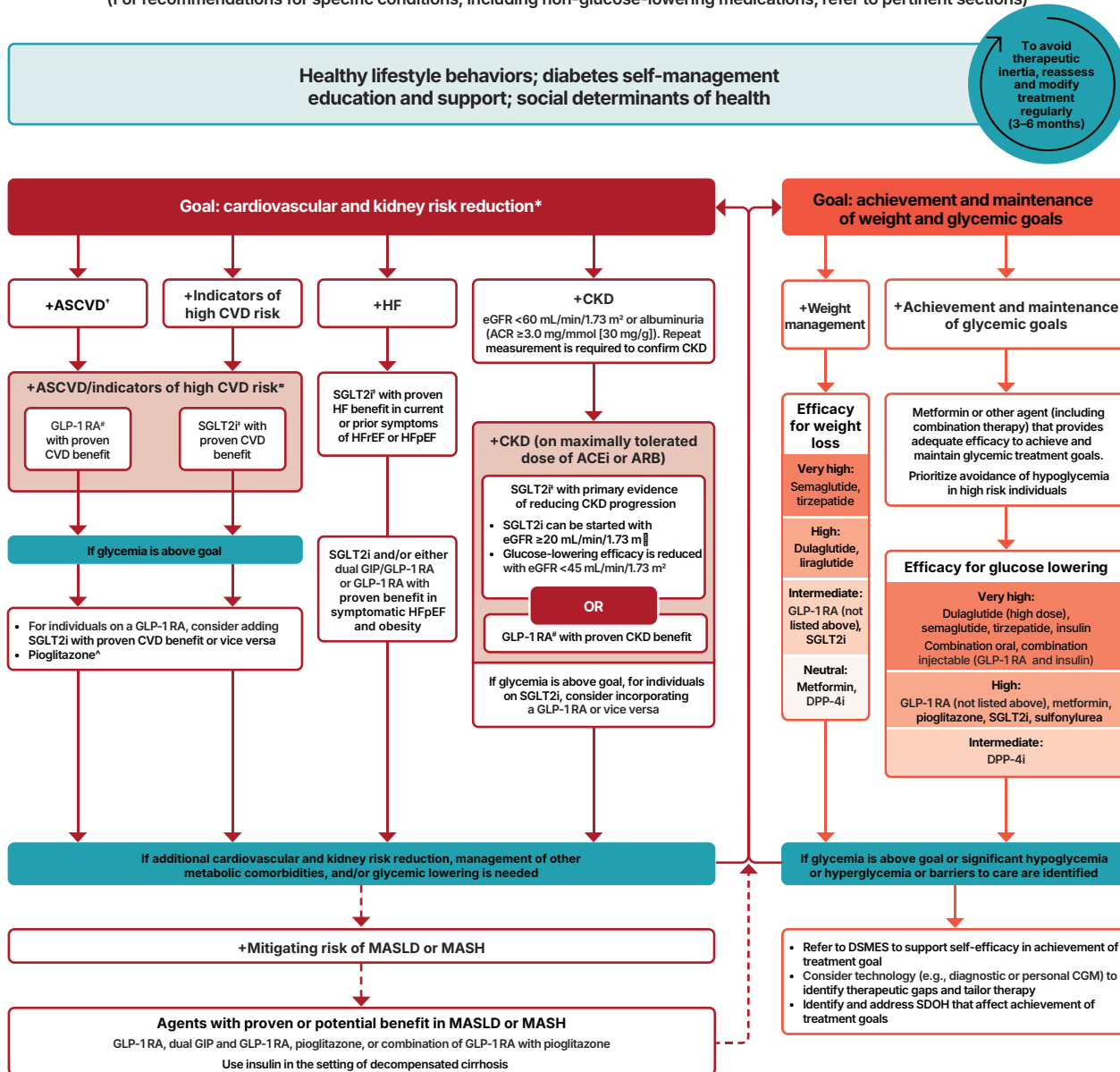
Translation of Research and Recommendations Into Clinical Practice

Over my long career, I have had the opportunity to work with not one, but two physicians associated with the landmark Diabetes Complications and Control Trial (DCCT) (19), both physicians long-term advocates of team-based care for people with diabetes. Pediatric endocrinologist Richard Mauseth, MD, hired me to work in his private practice along with a nurse. We were a small but very mighty multidisciplinary team that took care of >400 youth in Washington state with diabetes. My skill set quickly ramped up to include teaching patients how to administer insulin, as well as pump and sensor training. Dr. Mauseth was an early adopter of diabetes technology in the late 1990s. Every meter, pump, or sensor that a patient used was downloaded in the office, and the data were incorporated into the treatment plan.

In 2006, I graduated from pediatrics to adults when I was hired at the University of Washington (UW) Medicine Diabetes Institute. My job was to provide MNT services and coordinate the ADA-accredited diabetes Education Recognition Program (ERP), which was quite an accomplishment after my humble beginnings in 1988 when I taught my first class without much preparation. Working at the UW Medicine Diabetes Institute allowed me to work with another DCCT researcher, Irl Hirsch, MD. I truly appreciate all of his MNT and DSMES referrals as well as his trust

Use of glucose-lowering medications in the management of type 2 diabetes

(For recommendations for specific conditions, including non-glucose-lowering medications, refer to pertinent sections)



To avoid therapeutic inertia, reassess and modify treatment regularly (3–6 months)

* In people with HF, CKD, established CVD, or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be made irrespective of attainment of glycemic goal.

† ASCVD: Defined differently across CVOTs but all included individuals with established CVD (e.g., MI, stroke, and arterial revascularization procedure) and variably included conditions such as transient ischemic attack, unstable angina, amputation, and symptomatic or asymptomatic coronary artery disease. Indicators of high risk: While definitions vary, most comprise ≥55 years of age with two or more additional risk factors (including obesity, hypertension, smoking, dyslipidemia, or albuminuria)

‡ A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high risk CVD. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details.

For GLP-1 RAs, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and kidney end points in individuals with T2D with established or high risk of CVD. One kidney outcome trial demonstrated benefit in reducing persistent eGFR reduction and CV death for a GLP-1 RA in individuals with CKD and T2D.

‡ For SGLT2is, CV and kidney outcomes trials demonstrate their efficacy in reducing the risks of composite MACE, CV death, all-cause mortality, MI, HFrEF, and kidney outcomes in individuals with T2D and established or high risk of CVD.

^ Low-dose pioglitazone may be better tolerated and similarly effective as higher doses.

FIGURE 2 Use of glucose-lowering medications in the management of type 2 diabetes. The left side of the algorithm prioritizes mitigation of diabetes-related complications and end-organ effects, while the right side addresses weight and glucose management goals. ACEi, ACE inhibitor; ACR, albumin-to-creatinine ratio; ARB, angiotensin receptor blocker; ASCVD, atherosclerotic cardiovascular disease; CGM, continuous glucose monitoring; CKD, chronic kidney disease; CV, cardiovascular; CVD, cardiovascular disease; CVOT, cardiovascular outcomes trial; DPP-4i, dipeptidyl peptidase 4 inhibitor; DSMES, diabetes self-management education and support; eGFR, estimated glomerular filtration rate; GLP-1 RA, glucagon-like peptide 1 receptor agonist; HF, heart failure; HF_{rEF}, heart failure with reduced ejection fraction; HF_{pEF}, heart failure with preserved ejection fraction;

in my expertise over the years. In addition, he facilitated numerous opportunities for an RDN to present and write on diabetes nutrition, education, and technology topics all around the world. So supportive of the role of the RDN, he was awarded an honorary membership in the Academy in 2018.

My Final Chapter: Embedding Diabetes MNT and DSMES Services in Primary Care

It was Dr. Hirsch who started the conversation with the 14 UW Medicine Primary Care (UWMPC) clinics about providing diabetes education services embedded in primary care. While nutrition therapy services had been provided for several years, diabetes education was not. As a result of these conversations, in 2013 I was hired as a consultant to develop an ADA ERP to be delivered in primary care. The DSMES program was provided by a primary care registered dietitian staff member, Maureen Chomko, RD, CDCES, and a care management RN. Our pilot study revealed that an ADA ERP embedded in primary care delivered by an RDN/CDCES and care management RN was associated with increased enrollment in DSMES classes and a significant reduction of A1C and weight at 3 and 6 months post-DSMES (20). DSMES is now offered at all of the primary care clinics across the network.

In 2017, UW Medicine endocrinologist Savitha Subramanian, MD, hired me to assist her with a Centers for Medicare & Medicaid Innovation (CMMI) grant focusing on diabetes population health. The CMMI grant was conducted in UWMPC Network. When the grant ended, the UWMPC created a position for me to continue to grow these diabetes and nutrition education services. Based on our population health work in identifying patients with elevated A1C, the Medical Director of UWMPC asked us to develop and implement RDN/CDCES-led and care management RN-led medication management using an organization-approved diabetes medication adjustment protocol for antihyperglycemic agents and insulin. Dr. Subramanian also created for primary care providers a diabetes-focused examination template in the organization's electronic medical record. Another key component built into the electronic medical record was an order set for medication delegation and referrals to DSMES, MNT, and intensive behavioral therapy for obesity. We also developed a diabetes medication adjustment training and competency program to ensure that RDN/CDCES and RN staff were well equipped to use the medication algorithms. Research studies and practice papers report the role of the RDN and RN in the use of organization-approved medication adjustment protocols (21,22). The experienced RDN who has demonstrated competency in

medication adjustment and practicing within their scopes of practice can help to reduce clinical inertia and/or reduce risk of hypoglycemia and hyperglycemia (23).

Along the way the RDN/CDCES team has grown from two in 2013 to now seven in 2025. Since there always seems to be a shortage of diabetes care and education specialists, at UWMPC we trained and mentored new RDN staff to be able to sit for the CDCES or BC-ADM certification examinations within 1–2 years of hire. The RDN/CDCES team is also able to generate revenue, billing for a wide variety of services. Expanding access to DSMES and MNT to facilitate informed decision-making, self-care behaviors, and collaboration with the health care team is essential to assist the patient to meet health goals (13). Despite the reported benefits of DSMES and MNT, these services continue to be underused (13,24). Therefore, to reach a wider audience and address treatment gaps, the RDN/CDCES can deliver these services using a variety of educational formats, such as telemedicine. Both DSMES and MNT are benefits covered by Medicare for people with a diagnosis of diabetes (25,26). These services are also often covered by many commercial payers and Medicaid. However, it is imperative to advise patients to determine benefit coverage before obtaining services as benefit coverage can vary.

Medicare currently also offers a Chronic Care Management (CCM) benefit for beneficiaries with two or more chronic health conditions including diabetes, hypertension, cardiovascular disease, and obesity (27). The intent is improved continuity of care and ongoing support for managing multiple complex health issues, with the goal of reducing the need for emergency and hospital services. In the traditional fee-for-service system, the beneficiary can choose these services for an additional fee. In other care settings, such as a Federally Qualified Health Center, there is no additional fee. At UWMPC the care management RNs provide these services, but these services could also be provided by an RDN.

MNT, DSMES, and intensive behavioral therapy (IBT) for obesity visits have grown from a few hundred when we started to >5,000 in 2025. Of the RDN/CDCES visits at UWMPC, 60% were provided via telemedicine in 2024. Use of telemedicine reduces burden of travel and child care or does not tie up an exam room. In addition, the RDNs can literally see what the patient eats and what is in their cupboards and refrigerator, as well as provide training on medication administration and sensors. While many commercial insurance and Medicaid plans currently provide benefit coverage for MNT and DSMES provided via telehealth, some of the CMS telehealth flexibilities have been made permanent; others are temporary.

HHF, hospitalization for heart failure; MACE, major adverse cardiovascular events; MASH, metabolic dysfunction–associated steatohepatitis; MASLD, metabolic dysfunction–associated steatotic liver disease; MI, myocardial infarction; SDOH, social determinants of health; SGLT2i, sodium–glucose cotransporter 2 inhibitor; T2D, type 2 diabetes. Originally published in Davies et al. (6); reprinted from ADA “Standards of Care in Diabetes—2026” (1).

Therefore, Medicare, Medicaid, and commercial insurance recipients referred to MNT, DSMES, and IBT for obesity should be advised to confirm benefit coverage prior to receiving care provided via telehealth.

Evolving Role of the RDN/CDCES in Obesity Care and Education

As an RDN/CDCES, I have been working with incretin-based therapies since they were first approved by the U.S. Food and Drug Administration in 2005. At the UW Medicine Diabetes Institute and UWMPC, our standard approach for an individual with diabetes with a prescription for one of these medications would be a referral to the diabetes educators, care management RNs, or clinic pharmacist. One of these team members would provide education on how to administer and titrate the medication, and we would review potential side effects and long-term management strategies. For a great majority of people with diabetes using this approach it was very successful, resulting in improved clinical outcomes and weight loss—and, more importantly, continued use long-term.

Fast-forward to 2025, and one of the biggest contributors to the far-reaching shifts in the management of obesity has been the emergence of incretin-based therapies for use in people with and without type 2 diabetes (28). Health care professionals seem to be at a crossroads in terms of how to proceed to support these individuals. Setting realistic expectations for weight management, potential side effects, and need for ongoing treatment is important, given high medication discontinuation rates (28). These medications' efficacy in terms of increasing fullness, reducing hunger, and other aspects of appetite control appears to decrease the need for traditional behavioral strategies for caloric reduction (29). Concern also exists about potential adverse effects on muscle mass, and little is known about the changes to eating patterns and diet quality (30). In addition, macro- and micronutrient requirements of individuals on incretin-based therapies await guidelines. Healthy lifestyle behaviors are, and continue to be, the cornerstone of the treatment of both type 2 diabetes and obesity (30). HCPs should discuss the importance of balanced nutritional intake with all who are prescribed these medications and provide access to an RDN to support use and long-term weight maintenance strategies (28).

I was recently asked to be part of a writing group convened by the Academy to look at the evolving role of the RDN in obesity care. Our review of the literature revealed that the RDN care team member is well equipped to provide support to people with obesity for long-term use of incretin-based hormones (30). This publication is also full of helpful nutrition intervention strategies and resources for all health care professionals working with individuals with and without diabetes who are taking obesity medications. Questions resulting from this article and my

personal thoughts as my 40-year career is nearing its end include the following: Don't we need a long-term management approach for obesity care, just like diabetes? It's a chronic condition too. And shouldn't we implement strategies to support successful long-term use—just like we have provided and perfected in the diabetes world since 2005? I am also excited about the ADA's new Obesity Association and their "Standards of Care in Overweight and Obesity" (31); the first chapters available online (32). I look forward to learning about how the RDNs and CDCES will be involved in this new association. I'll end here—by passing the baton and this challenge to the next generation of RDN/CDCES and multidisciplinary care team members.

In Closing

Over my long professional career as a diabetes nutrition educator, the ADA has been a wonderful multidisciplinary professional home. The ADA has provided me with not only up-to-date patient care information, resources, and continuing education but also many opportunities to contribute as a volunteer. And along the way, I have established lifelong professional colleagues and friendships.

ACKNOWLEDGMENTS

I would like to thank the Diabetes Dietetic Practice Group of the Academy and their 4,000 members working in this space for the mentoring and leadership experience training early in my career. I also thank Melinda Maryniuk for putting forward my nomination for this award and thank Drs. Irl Hirsch and Anne Peters for their letters of support. I also thank my family for their love and support over the years. I have had a wonderful and meaningful career as an RDN and a CDCES team member and feel very grateful to have contributed to this important work.

DUALITY OF INTEREST

No potential conflicts of interest relevant to this article were reported.

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