



# Health and Human Services

## Texas Diabetes Council

April 23, 2026

---

*This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.*

---





[Texas Diabetes Council](#) addresses issues affecting people with diabetes in Texas and advises the Texas Legislature on legislation needed to develop and maintain a statewide system of quality education services for all people with diabetes and health care professionals who offer diabetes treatment and education.

The Texas Legislature amended the [Health and Safety Code 103](#) to establish the Texas Diabetes Council in 1983. In 1984, Legislature amended [Title 25, Health Services, Part 9, Rule §651.1](#) to establish conduction of meetings. Since then, TDC members have worked with private and public healthcare organizations to promote diabetes prevention and awareness throughout the state. Texas Diabetes Council (TDC) addresses issues affecting people with diabetes in Texas. It advises the Texas Legislature on needed legislation to develop and maintain a statewide system of quality education services for all people with diabetes and health care professionals who offer diabetes treatment and education.

The TDC is required to conduct an assessment of the state's diabetes prevention and treatment programs. The TDC is required to use the results of the assessment to develop a prevention and treatment plan by November 1 of odd-numbered years.

The current [Texas Diabetes State Plan](#) shows priority areas that build on past accomplishments and use current national, state, and local efforts to improve diabetes education and management in Texas. Work in the state plan's priority areas depends on the Legislature's continued funding and support.

The Texas Diabetes State Plan priority areas are:

- Increasing access to diabetes treatments and education.
- Addressing co-morbidities and reducing complications in diabetes care.

### **Council Statements**

**Vision:** A Texas free of diabetes and its complications

**Mission:** To effectively reduce the health and economic burdens of diabetes in Texas

**Position:** Specific initiatives to improve outcomes and minimize barriers to impact diabetes care in Texas communities for improved delivery of care through system reforms that lead to increased access and high quality, affordable, effective, and efficient care for people with diabetes and coordination of State services.

## Members

Name	City	Membership Category	Term Expires*	Public Health Region
Aida "Letty" Moreno-Brown, RD, LD	El Paso	General public member with expertise or demonstrated commitment to diabetes issues	2027	9/10
K. Renee' Yarbrough-Yale, DNP, APRN, ACCNS-AG, CDCES	North Richland Hills	Consumer member	2031	2/3
Dirrell Jones, JD	Farmers Branch	General public member with expertise or demonstrated commitment to diabetes issues	2031	2/3
Jason Ryan, JD	Houston	Consumer member	2031	6/5 South
Maryanne Strobel, RN, MSN, CDCES	Cypress	Registered nurse with a specialization in diabetes education and training	2027	6/5 South
Vice-Chair Ninfa Peña-Purcell, PhD	College Station	General public member with expertise or demonstrated commitment to diabetes issues	2027	7
Michael Kelly, PhD	El Paso	Member with experience and training in public health policy	2031	9/10
Chair Chris Carmona, JD	Houston	General public member with expertise or demonstrated commitment to diabetes issues	2029	6/5 South
Sharon Lemons, MS, RD, CDCES, FAND, LD	Saginaw	Registered and licensed dietitian	2029	2/3
John Trischitti III, MLS	Midland	Consumer Member	2029	9/10

## Nonvoting State Agency Members

Laura Cervantes, MSN, RN, CTCM	Teacher Retirement System of Texas
Amy Chamberlain, MS	Employees Retirement System of Texas
Lisa Golden, MA, ED, HD, CRC, CDCES	Texas Workforce Commission
Kelly Fegan-Bohm, MD, MPH, MA	Texas Department of State Health Services
Shannon Teer, RN	Texas Health and Human Services Commission



## **1. Welcome, logistical announcements, and roll call**

The meeting was convened by Chris Carmona, Chair.

**2. Consideration of January 29, 2026, draft meeting minutes**. The minutes were approved as drafted.

## **3. Presentation from CCS Medical: Critical Success Factors in CGM Adoption & Adherence** ([CCS Medical | The Smart way to Manage Chronic Conditions™](#))

**Summary** Connie Dennis (SVP & Chief Clinical Officer, CCS Medical) presented on “critical success factors” for continuous glucose monitoring (CGM) adoption and sustained use. Diabetes affects more than 3 million adults in Texas and drives over \$30B in annual costs. CGM can improve A1C/GMI, time-in-range, reduce hypo/hyperglycemia, and is associated with fewer ER visits/hospitalizations (noting large reductions in acute diabetes hospitalizations in studies).

80% of eligible individuals are not using CGMs (either never start or discontinue), despite improved technology and expanded coverage. Barriers discussed by council members and presenter included affordability, uneven access (including “pharmacy deserts”), device onboarding/training gaps, complexity of alerts/app integration, sensor placement limitations and durability (sensors getting knocked off leading to replacement/cost issues), and broader social/structural factors (digital access, support systems).

Success factors impacting sustained use:

- Guided onboarding to prevent devices sitting unused “on the shelf.”
- Education on interpreting data and managing alarms safely (including risk of turning off alarms leading to severe events).
- Early support in the first ~90 days/first 3 months when drop-off risk is highest.
- Addressing social factors like finances and loneliness (noting loneliness as a contributor to low motivation/depression/disengagement).

Real-world channel observations (pharmacy vs DME/home medical supply). There is: higher adherence in DME channel over 6/9/12 months; lower total annual medical costs among adherent patients in DME vs pharmacy cohorts; There is a higher likelihood of

restarting after discontinuation in DME—suggesting the surrounding support model (onboarding, education, follow-up, care team connection) matters.

## Presentation

### In both Texas and the nation Diabetes remains a stubborn Public Health challenge

**Within Texas diabetes continues to have major impact to individuals and the health system**

~3,127,800 adults in Texas, (13.20% of the adult population) have diabetes<sup>1</sup>. Some regions have rates >20%<sup>1</sup>

~230,000 adults/year in are diagnosed with diabetes<sup>1</sup>

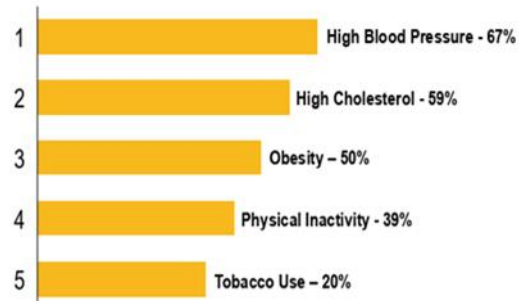
Diabetes is the 8<sup>th</sup> leading cause of death in TX<sup>1</sup>

Medicaid costs for Diabetes near ~\$500B/year<sup>21</sup>

Diagnosed diabetes costs an estimated \$34.3B/year (~\$25B in direct expenses; \$9.0B from lost productivity)<sup>1</sup>

**And patients face increased co-morbidities from the disease**

#### Top Five Diabetes Comorbidities (2025)<sup>2</sup>

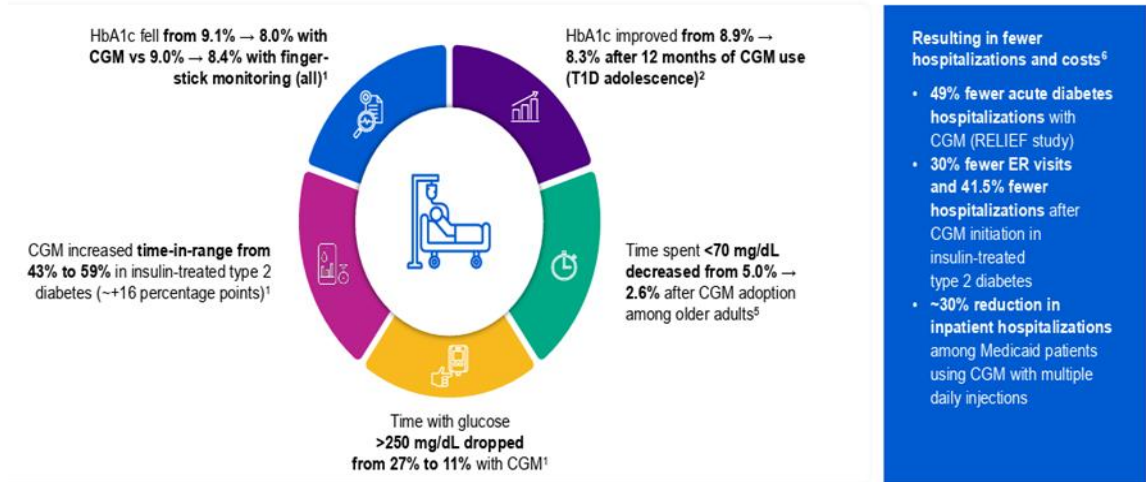


*How to read: 67% of Texan adults who are living with diabetes are also living with high blood pressure*

### Technology especially CGMs have advanced at a rapid pace...

Area of Innovation	Key Data Point
Automated insulin delivery (CGM + pump integration)	>1.2 million automated insulin delivery (AID) systems integrating CGM sensors with insulin pumps have been distributed globally <sup>1</sup>
CGM accuracy improvement	Sensor accuracy improved from ~20% Mean Accurate Relative Difference (MARD) <sup>2</sup> in early CGMs to ~8% in modern sensors (~2.5x improvement in accuracy)
Device usability innovation	CGM warm-up times reduced from ~120 minutes to ~30 minutes <sup>3</sup> , and modern sensors no longer require routine finger-stick calibration
Scale of CGM ecosystem	~7.5 million active CGM users globally and >50 million CGM sensors shipped annually <sup>4</sup>



**...and have demonstrated and measurable clinical impact**



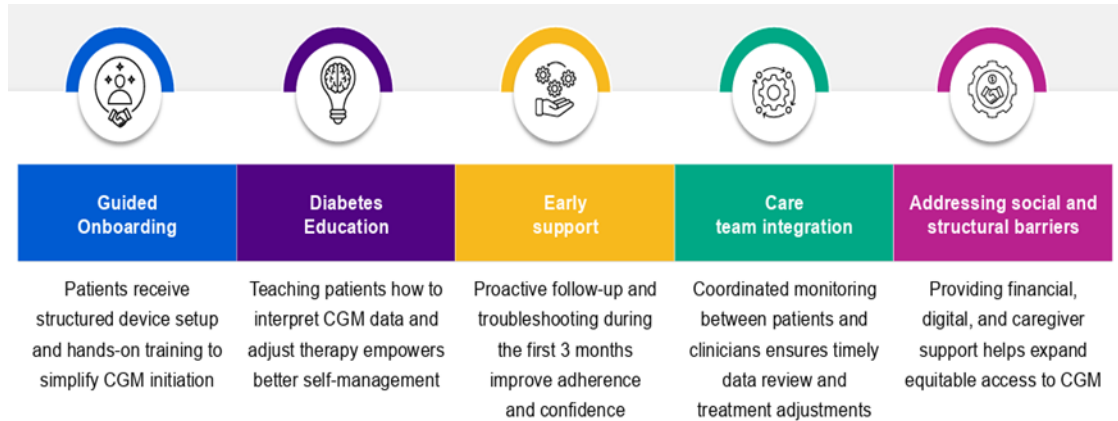
**However, evidence suggests many individuals are not using the technology.**

Eighty percent of individuals eligible for CGM are not using the technology, despite strong clinical evidence and expanding insurance coverage . This raises critical questions on how despite a strong technology environment patients are not leveraging solutions that can drastically improve their health

**This may stem directly from barriers to both accessing and sustaining adoption of CGMs**

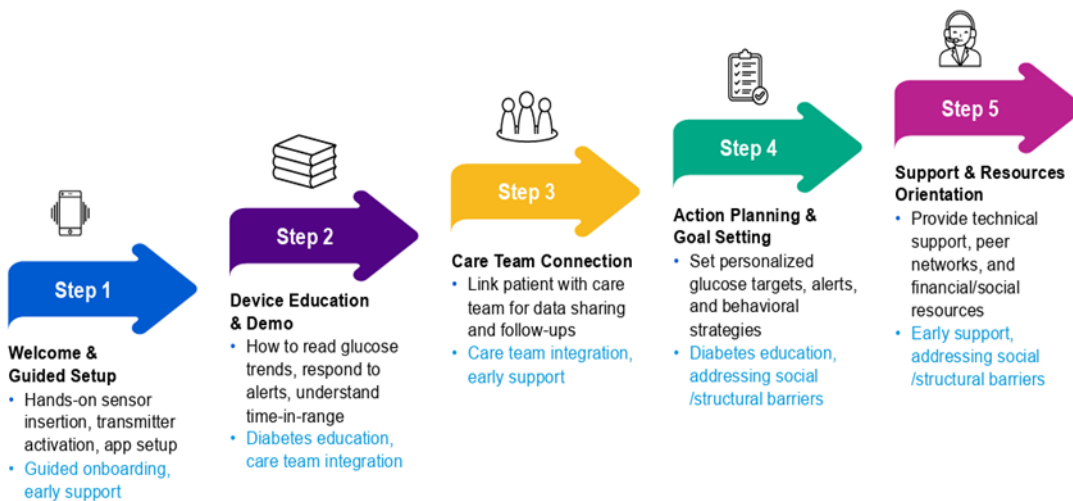
 <b>Access challenges</b>	<b>Poor, consistent access to pharmacies (i.e. pharmacy deserts)</b>	<ul style="list-style-type: none"> <li>• Access to pharmacies is uneven with <b>many Texans living in pharmacy “deserts”</b> (Less than 4 pharmacists/100,000 people) with others at-risk! (~40% qualify as pharmacy deserts, 1.8M Texans rely on at-risk pharmacies<sup>2</sup>); <b>Low-income, Black, and Hispanic communities are significantly more affected</b> with millions facing reduced access to essential medications and care</li> </ul>	<b>ACCESS + ADOPTION</b>  <b>ONGOING USE OF CGM</b>
	<b>Delays to supplies + limited support</b>	<ul style="list-style-type: none"> <li>• Patients can experience <b>delays with pharmacy inventory</b></li> <li>• Limited structured onboarding programs mean patients often <b>receive devices without hands-on training or troubleshooting support</b></li> </ul>	
	<b>Lack of Education</b>	<ul style="list-style-type: none"> <li>• Many patients <b>don’t understand how to interpret CGM data</b> or integrate it into daily insulin adjustments.</li> <li>• Clinicians sometimes <b>lack time or CGM-specific training</b> to guide patients on device use and data review</li> </ul>	
 <b>Adoption challenges</b>	<b>Technology Burden</b>	<ul style="list-style-type: none"> <li>• Frequent device alerts, sensor changes, or transmitter issues can <b>increase perceived complexity</b>, discouraging consistent use</li> <li>• Integration with other digital health tools or apps is often <b>non-intuitive</b>, adding friction for patients</li> </ul>	
<b>Social Determinants of Health</b>	<ul style="list-style-type: none"> <li>• High out-of-pocket costs or insurance gaps make CGM <b>financially inaccessible</b> for underserved populations</li> <li>• Limited access to digital literacy, reliable internet, or supportive caregivers <b>reduces effective adoption and sustained use</b></li> </ul>		

**There are several critical success factors to ensure patients adopt and consistently use the technology**



**All of these success factors should play into how a patient experiences CGM in the first ~90 days**

Illustrative flow



**Taken together, the channel by which a patient onboards to CGM, receives supplies and has for support matters.** Recent studies highlight impact of channel on CGM adoption and adherence



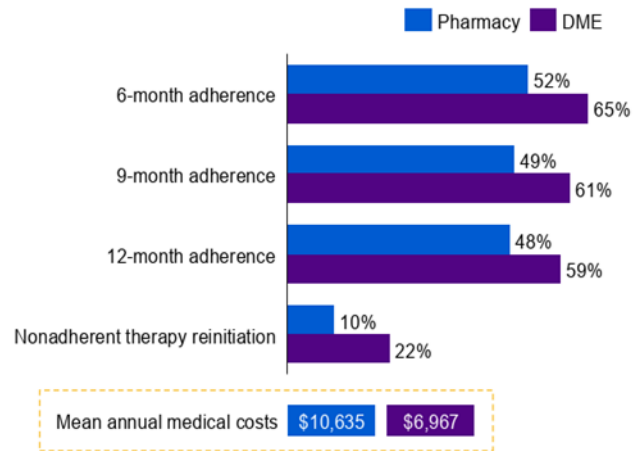
**Higher adherence with durable medical equipment (DME):** 6, 9, 12 months adherence rates: **65%, 61%, 59%** vs. pharmacy **52%, 49%, 48%** (P<.001)



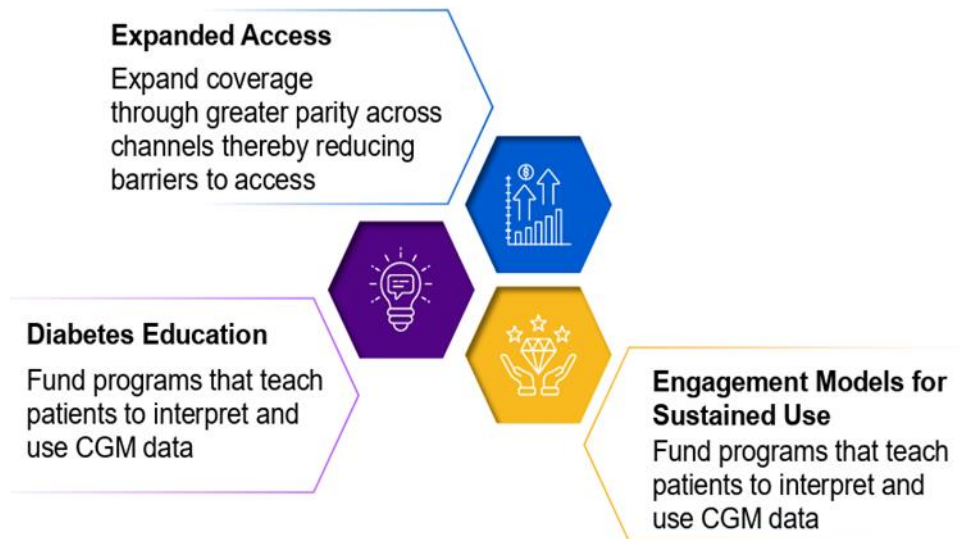
**Lower costs for adherent patients:** Mean annual medical costs **\$6,967 (DME) vs. \$10,635 (pharmacy)** – 53% higher in pharmacy cohort



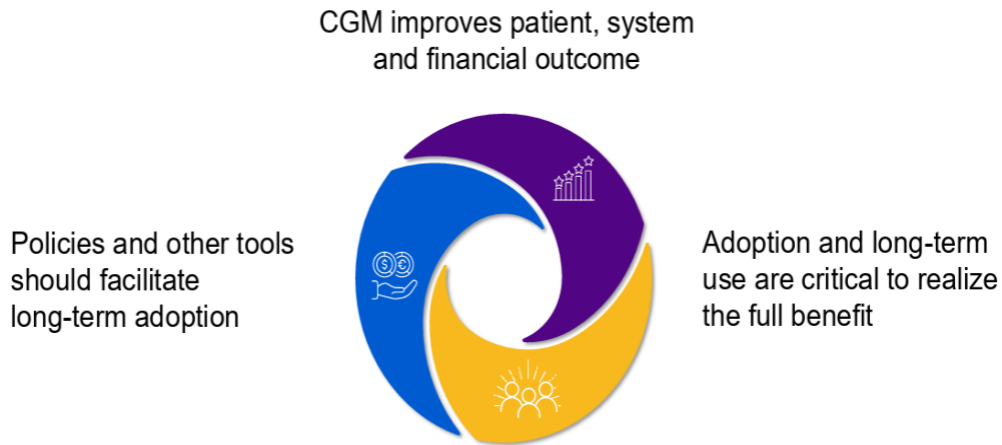
**Higher therapy reinitiation in nonadherent DME patients:** **22% vs. 10%** for pharmacy (P<.001)



**Therefore, policies at the State level should focus on improving CGM adoption to drive system outcomes**



**In closing – incentivizing long-term adoption and use of CGM and other technology drive the impact we desire**



**Discussion**

Michael Kelly asked about steps/best practices and timing; Connie Dennis confirmed the steps as best practice that is aligned with ADA guidance and offered to email a more detailed timing table.

There was discussion on who should provide onboarding/education support; presenter suggested certified diabetes care and education specialists can provide onboarding support.

Dr. Pena-Purcell stressed integrating CGM education with DSMES (diabetes self-management education/support), so lifestyle change and care-team integration are not treated as a “device-only” effort. The presenter noted DSMES participation is very low (3–4% of eligible individuals) and advocated leveraging CGM initiation as a catalyst for broader self-management engagement.

A member shared lived experience as a pump-dependent diabetic. CGM/pump improves quality of life and glycemic control, but cost and supply access remain major barriers.

Lisa Golden emphasized CGM/pumps as critical accommodations for people with disabilities (who have higher diabetes prevalence) and noted eligibility and affordability



gaps (including coverage criteria and insurance “gap” after disability/job loss) and called for both device training and DSMES.

There were questions about early detection of type 1 diabetes and issues around CGM fitting into pre-diagnosis were raised; presenter deferred, noting it was outside her research.

The Chair asked where the council can direct Texans for CGM-related education beyond providers. The presenter pointed to DSMES programs (provider referral), support from home medical suppliers, and community health workers/local diabetes supports.

The Chair asked about insulin pumps for type 2 diabetes and higher insulin needs. The presenter saw potential for pumps in some type 2 populations but had not encountered specific research/technology on higher-capacity needs.

#### **4. Overview: American Diabetes Association update**

**Summary** Douglas Dunsavage (American Diabetes Association) and Joel Romo (Texana Public Affairs, on behalf of ADA) provided an interim legislative and committee update.

- Public Health Committee focus includes chronic disease workforce/access, HHSC/DSHS oversight, and emerging issues (AI, telehealth, public health trends).
- The House Select Committee on Health Care Affordability is examining drivers of costs/access, workforce capacity, utilization, and structural barriers; positioned as a platform for affordability/access policy solutions.

The ADA noted continued monitoring of Medicaid regulations/coverage for CGMs via both pharmacy and DME. He commented on the Governor announcement of \$60M directed to rural healthcare hospitals/clinics; clinics in rural areas may apply, with expected distribution later summer/fall. [Gov. Abbott, HHSC Announce \\$60 Million In Federal Funding To 'Make Rural Texans Healthy Again' | texasinsider | texasinsider.org](#)

The ADA plans to monitor the upcoming affordability committee hearing and pursue opportunities to testify on Diabetes Prevention Program (DPP) and obesity treatment (including lifestyle/behavioral therapy, not only GLP-1s).



Sunset Advisory Commission review of HHSC is seen as a major interim process and the ADA plans to provide stakeholder input on prevention/awareness programs.

SB 1677 amputation prevention study at UTSA is underway; report to the Legislature expected in November.

DPP/obesity-related study rider in SB 1 is underway at HHSC in collaboration with Episcopal Health Foundation; results expected in November.

ADA shared plans to distribute a one-pager and QR code for the Diabetes Prevention Alliance to help connect rural clinics/stakeholders as Rural Health Transformation resources roll out. [The Diabetes Prevention Alliance Will Combat Diabetes in Southern States | American Diabetes Association](#)

## **Presentation**

### **Overview of Public Health Committee charges and alignment with chronic disease priorities:**

- Committee scope centers on chronic disease, workforce, and access, with oversight of HHSC/DSHS and evaluation of emerging issues like AI, telehealth, and public health trends.
- Chronic disease charge creates a clear entry point for obesity and diabetes policy, aligned with legislative focus on reducing morbidity, mortality, and long-term costs.
- Existing policy pathways (e.g., Medicaid obesity treatment + DPP) position us to integrate prevention and treatment into broader chronic disease strategies under this charge.

### **House Select Committee on Health Care Affordability – Scope & Focus**

- Examines drivers of health care cost and access across Texas, with a cross-jurisdictional approach to affordability challenges.
- Evaluates system-wide factors impacting care delivery, including workforce capacity, utilization, and structural barriers to access.
- Creates a platform for policy solutions aimed at improving affordability, access, and outcomes across the health system.



### **Amputation Prevention – Senate Bill 1677 (Sen. Menendez/Rep. VanDeaver)**

- Texas Senate Bill 1677 mandates a study by a top-tier research university (UTSA) to explore preventing and reducing diabetes-related amputations.
- Currently, the amputation study is underway, and we are working with UTSA School of Public Health and consensus partners from around the state to garner input and implement this study throughout the year.
- The findings will be reported back to the Governor and legislature by September 2026.

### **Diabetes Prevention – SB 1 (89th Leg.) – Study Language**

- The Health and Human Services Commission (HHSC), in collaboration with the Department of State Health Services, is directed to study the cost-effectiveness and feasibility of a diabetes prevention program for Medicaid recipients.
- In addition, the study evaluates alternative interventions for those at risk of Type 2 diabetes including obesity treatments.
- We are working with the Department of State Health Services, HHSC and the Episcopal Health Foundation identifying data, developing prevention recommendations, and working to propose policy solutions for treatment access, including innovative therapies
- HHSC must submit a report with findings and recommendations to the Governor and legislative committees by November 1, 2026.

## **Discussion**

The Council asked whether specific amounts from rural grants are allocated to diabetes prevention; ADA did not have a specific figure but stated some portion is allocated to chronic disease and emphasized the need to influence investments toward diabetes and obesity prevention.

Chair reminded members that ADA can advocate/lobby for priorities the council cannot directly lobby for, including items related to the 2025 and future state plans.

## **5. Update on Proposal Rule Packet for proposed amendments to Texas Administrative Code, Title 25, Part 9, Rule §651, Conduct of Council Meetings**



Rachel Wiseman (DSHS) updated on proposed rule packet amendments to TAC Title 25, Part 9 (Council Meetings): published March 20 in the Texas Register with plain-language summary on the council website.

Public comment period closed (Monday) with no comments received; no further council steps required, and DSHS will proceed to finalize/adopt the rules within the six-month adoption window.

Published March 20. [Title 25, Part 9, Rule §651.1.](#)

## **6. Updates from workgroup**

Workgroup update was led by Dr. Pena-Purcell, with comments from Renee Yarborough and Dr. Kelly:

- Rural Health Transformation Grant overview was presented in the workgroup by Klaus Madsen.
- Dr. Adrian Billings presented on severe rural infrastructure/resource gaps for diabetes care (primary care deserts, pharmacy deserts, limited support).
- Diabetes prevention presentation followed.

Multiple members emphasized the need for a collaborative, statewide strategy to avoid siloed spending and to maximize impact of large federal/state rural investments.

Dr. Kelly raised concerns about rural capacity to write competitive grants and suggested strengthening linkages between resource-rich urban areas (endocrinology, diabetes education specialists) and rural communities.

The Chair discussed adding a state plan action item to help guide/align future funding allocations with council priorities.

## **7. Finalize workgroup mission statement**

Workgroup mission statement reviewed on-screen and accepted without changes; Michael Kelly advised not “sacrificing the good for the perfect.”

The Chair reiterated a governance reminder: DSHS/HHSC staff are partners supporting the council’s work, not employees of TDC, so future statements/tasks should avoid directives implying staff report to the council.



The final workgroup mission statement:

***“Serve as the primary advisory body to the Texas Diabetes Council members by synthesizing clinical expertise in practice, community health education and outreach, and epidemiology data to inform evidence-based recommendations for the state plan that advance diabetes prevention, treatment, education, and support across Texas.”***

## **8. Updates from state agency representatives**

**Department of State Health Services** [2025-texas-diabetes-council-assessment-report.pdf](#).

- Staffing updates were mentioned
- DPCP hosted the first quarterly state engagement call of 2026, focused on the Medicare Diabetes Prevention Program (MDPP), including how to become MDPP suppliers and how to bill for reimbursement.
- DPCP submitted the year four CDC grant continuation application packet for review and also applied for a late-breaker CDC supplemental funding opportunity targeted at expanding DPP and DSMES.
- DPCP is preparing guidance to support contractors' grant activities for the upcoming fiscal year.
- “Diabetes News You Can Use” newsletter will go out in May; people can email [diabetes@dshs.texas.gov](mailto:diabetes@dshs.texas.gov) to join the distribution list.

**Health and Human Services Commission.** No report

**Teacher Retirement System of Texas.** [Home | Teacher Retirement System of Texas](#)

No report

**Employees Retirement System of Texas.** [Type-2-Diabetes-Prevention-Program.pdf](#)

No report

**Texas Workforce Commission.** [diabetes-program-twc.pdf](#) commented that 21.9% of people with disabilities have diabetes and stressed the need for technology, education, and tools; also highlighted a “Diabetes At Work” project to help employers/supervisors better support employees with diabetes.



## **9. General announcements from members**

The Chair opened the floor on how to move work “from paper to a finished product in the field,” acknowledging frustration about when results of committee work will be seen. A member recommended more structured, facilitated work group meetings with specific agendas designed to produce action items (not just presentations), especially given new funding developments and to inform the next strategic plan.

It was Clarified that the Rural Health Transformation funding is under HHS and a request was made to invite an HHS representative to a future work group meeting to explain their approach to the funding and what role the committee/work group could play.

**10. Review of action items and agenda items for next meeting.** None reported

**11. Upcoming meeting dates.** Thursday, July 23, 2026, 1pm; Thursday, October 22, 2026, 1pm

## **12. .Public comment.**

**Godson Nkori, founder of a dietary nutrition startup, sharing “Quickredients,”** presented an app consolidating chain restaurant menu nutrition/ingredient information to help users filter menu items by carbs, sugar, and other nutrients to support dining-out decisions. [QuickredientsHome](#)

**13. Adjourn.** There being no further business, the meeting was adjourned.

---

*The information contained in this publication is the property of Texas Insight and is considered confidential and may contain proprietary information. It is meant solely for the intended recipient. Access to this published information by anyone else is unauthorized unless Texas Insight grants permission. If you are not the intended recipient, any disclosure, copying, distribution or any action taken or omitted in reliance on this is prohibited. The views expressed in this publication are, unless otherwise stated, those of the author and not those of Texas Insight or its management.*

---