Summary of American Diabetes Association

STANDARDS OF CARE IN DIABETES - 2026

Diabetes Care 2026;49(Supplement_1):S6–S12

INDEX

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 trial at one or more institutions • Evidence from a meta-analysis that incorporated quality ratings in the analysis
B	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

1. DIAGNOSIS AND CLASSIFICATION OF DIABETES: STANDARDS OF CARE IN DIABETES–2026

CLASSIFICATION

Diabetes Care 2026;49(Suppl. 1):S27–S49

Recommendations

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

Diabetes is classified conventionally into several clinical categories (e.g., type 1 or type 2 diabetes, gestational diabetes mellitus, and other specific types derived from other causes, such as monogenic diabetes, exocrine pancreatic disorders, and high-risk medications):

1. Type 1 diabetes (due to autoimmune β-cell destruction, usually leading to absolute insulin deficiency, including latent autoimmune diabetes in adults)
2. Type 2 diabetes (due to a nonautoimmune progressive loss of adequate β-cell insulin secretion, frequently on the background of insulin resistance)
3. Specific types of diabetes due to other causes, e.g., monogenic diabetes syndromes, diseases of the exocrine pancreas, and drug- or chemical-induced diabetes
4. Gestational diabetes mellitus (diabetes diagnosed in the second or third trimester of pregnancy that was not clearly overt diabetes prior to gestation or other types of diabetes occurring throughout pregnancy, such as type 1 diabetes)

Table 1: Staging of type 1 diabetes

	Stage 1	Stage 2	Stage 3
Characteristics	• Autoimmunity • Normoglycemia • Presymptomatic	• Autoimmunity • Dysglycemia • Presymptomatic	• Autoimmunity • Overt hyperglycemia • Symptomatic
Diagnostic criteria	• Multiple islet autoantibodies • No IGT or IFG, normal A1C	• Islet autoantibodies (usually multiple) • Dysglycemia: - IFG: FPG 100–125 mg/dL (5.6–6.9 mmol/L) or - IGT: 2-h PG 140–199 mg/dL (7.8–11.0 mmol/L) or A1C 5.7–6.4% (39–47 mmol/mol) **or** ≥10% increase in A1C	• Autoantibodies may become absent • Diabetes by standard criteria

FPG, fasting plasma glucose; IFG, impaired fasting glucose; IGT, impaired glucose tolerance; 2-h PG, 2-h plasma glucose. Alternative additional stage 2 diagnostic criteria of 30-, 60-, or 90-min plasma glucose on oral glucose tolerance test ≥200 mg/dL (≥11.1 mmol/L) and confirmatory testing in those aged ≥18 years have been used in clinical trials. Dysglycemia can be defined by one or more criteria as outlined in the table.

Criteria for the diagnosis of diabetes

Table 2: Criteria for the diagnosis of diabetes in nonpregnant individuals

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

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

Use of A1C for Screening and Diagnosis of Diabetes

Recommendations

- The A1C test should be performed using a method that is certified by the National Glycohemoglobin Standardization Program (NGSP) as traceable to the Diabetes Control and Complications Trial (DCCT) reference assay. **B**
- Point-of-care A1C testing for diabetes screening and diagnosis should be restricted to devices approved for diagnosis by the U.S. Food and Drug Administration at Clinical Laboratory Improvement Amendments–certified laboratories that perform testing of moderate complexity or higher by trained personnel. **B**
- Evaluate for the possibility of a problem or interference with either test when there is consistent and substantial discordance between blood glucose values and A1C test results. **B**
- In conditions associated with an altered relationship between A1C and glycemia, such as some hemoglobin variants, pregnancy, glucose-6-phosphate dehydrogenase deficiency, HIV, and conditions that may alter red blood cell turnover, plasma glucose criteria should be used to diagnose diabetes. **B**

TYPE 1 DIABETES

Recommendations

- Screen for presymptomatic type 1 diabetes by testing autoantibodies against insulin (IA), glutamic acid decarboxylase (GAD), islet antigen 2 (IA-2), or zinc transporter 8 (ZnT8). **B**
- Autoantibody-based screening for presymptomatic type 1 diabetes should be offered to those with a family history of type 1 diabetes or otherwise known elevated genetic risk. **B**
- Individuals with screening results positive for one or more islet autoantibodies should be evaluated for stage 3 (overt) type 1 diabetes (using A1C, urinalysis, and/or plasma glucose), which would require prompt clinical management and education. **B**
- Individuals with multiple confirmed islet autoantibodies and without overt type 1 diabetes have a high risk for progression to stage 3 type 1 diabetes and should be referred to a specialized center for metabolic staging, education, and consideration of prevention trials or approved treatments (e.g., teplizumab). **B**
- 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**
- 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**
- Standardized islet autoantibody tests are recommended for classification of diabetes in adults who have phenotypic risk factors that overlap with those for type 1 diabetes (e.g., younger age at diagnosis, unintentional weight loss, ketoacidosis, or short time to insulin treatment). **E**

PREDIABETES AND TYPE 2 DIABETES

Recommendations

- Screening for risk of prediabetes and type 2 diabetes with an assessment of risk factors or validated risk calculator should be done in asymptomatic adults. **B**
- Testing for prediabetes or type 2 diabetes in asymptomatic people should be considered in adults of any age with overweight or obesity who have one or more risk factors. **B**
- For all other people, screening should begin at age 35 years. **B**
- In people without prediabetes or diabetes after screening, repeat screening recommended at a

minimum of 3-year intervals is reasonable, sooner with symptoms or change in risk (e.g., weight gain). **C**

- To screen for prediabetes and type 2 diabetes, FPG, 2-h PG during 75-g OGTT, and A1C are each appropriate. **B**
- When using OGTT as a screening tool for prediabetes or diabetes, adequate carbohydrate intake (at least 150 g/day) should be assured for 3 days prior to testing. **C**
- Risk-based screening for prediabetes or type 2 diabetes should be considered after the onset of puberty or after 10 years of age, whichever occurs earlier, in children and adolescents with overweight (BMI ≥ 85th percentile) or obesity (BMI ≥ 95th percentile) and who have one or more risk factors for diabetes. **B**
- Consider screening people for prediabetes or diabetes if they are on certain medications, such as statins, thiazide diuretics, and some HIV medications, as these agents are known to increase the risk of these conditions. **C**
- In people who are prescribed second-generation antipsychotic medications, screen for prediabetes and diabetes at baseline and repeat 12–16 weeks after medication initiation or sooner, if clinically indicated, and annually thereafter. **B**
- People with HIV should be screened for diabetes and prediabetes with an FPG test before starting antiretroviral therapy, at the time of switching antiretroviral therapy, and 3–6 months after starting or switching antiretroviral therapy. If initial screening results are normal, FPG should be checked annually. **E**
- Monitor postprandial or random glucose levels with recurrent or long-term use of glucocorticoids. **B**

Criteria for screening for diabetes or prediabetes in asymptomatic adults

Recommendations

1. Testing should be considered in adults with overweight or obesity (BMI ≥25 kg/m^2 or ≥23 kg/m^2 in individuals of Asian ancestry) who have one or more of the following risk factors:
   - First-degree relative with diabetes
   - High-risk race, ethnicity, and ancestry (e.g., African American, Latino, Native American, Asian American)
   - History of cardiovascular disease
   - Hypertension (≥130/80 mmHg or on therapy for hypertension)
   - HDL cholesterol level <35 mg/dL (<0.9 mmol/L) and/or triglyceride level >250 mg/dL (>2.8 mmol/L)
   - Individuals with polycystic ovary syndrome
   - Physical inactivity
   - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans, metabolic dysfunction-associated steatotic liver disease)
2. People with prediabetes (A1C ≥5.7% [≥39 mmol/mol], IGT, or IFG) should be tested yearly.
3. People who were diagnosed with GDM should have testing at least every 1–3 years.
4. For all other people, testing should begin at age 35 years.
5. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.
6. Individuals in other high-risk groups (e.g., people with HIV, exposure to high-risk medicines, evidence of periodontal disease, history of pancreatitis) should also be closely monitored.

GDM, gestational diabetes mellitus; IFG, impaired fasting glucose; IGT, impaired glucose tolerance.

Risk-based screening for type 2 diabetes or prediabetes in asymptomatic children and adolescents in a clinical setting

Recommendations

Screening should be considered in youth* who have overweight (≥ 85th percentile) or obesity (≥ 95th percentile) and who have one or more additional risk factors:

- Maternal history of diabetes or GDM during the child's gestation.
- Family history of type 2 diabetes in first- or second-degree relative.
- High-risk race, ethnicity, and ancestry.
- Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovary syndrome, large- or small-forgestational-age birth weight).

GDM, gestational diabetes mellitus. *After the onset of puberty or after 10 years of age, whichever occurs earlier. If tests are normal, repeat testing at a minimum of 3-year intervals (or more frequently if BMI is increasing or risk factor profile is deteriorating) is recommended. Reports of type 2 diabetes before age 10 years exist, and this can be considered with numerous risk factors.

Table 3: Criteria defining prediabetes in nonpregnant individuals

A1C 5.7–6.4% (39–47 mmol/mol)
OR
FPG 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmol/L) (IFG)
OR
2-h PG during 75-g OGTT 140 mg/dL (7.8 mmol/L) to 199 mg/dL (11.0 mmol/L) (IGT)

For all three tests, risk is continuous, extending below the lower limit of the range and becoming disproportionately greater at the higher end of the range. FPG, fasting plasma glucose; IFG, impaired fasting glucose; IGT, impaired glucose tolerance; OGTT, oral glucose tolerance test; 2-h PG, 2-h plasma glucose.

Cystic fibrosis–Related diabetes

Recommendations

- Annual screening for cystic fibrosis–related diabetes (CFRD) should begin by age 10 years in all people with cystic fibrosis, preferably using OGTT. **B**
- If an OGTT is not feasible, A1C can be used as an alternative method as part of a two-step screening strategy. Individuals with A1C values between 5.5% and 6.4% (37 and 47 mmol/mol, respectively) should undergo an OGTT within 3 months. C An A1C value of ≥6.5% (≥48 mmol/mol) is consistent with a diagnosis of CFRD. **B**
- Beginning 5 years after the diagnosis of CFRD, annual monitoring for complications of diabetes is recommended. **E**

POSTTRANSPLANTATION DIABETES MELLITUS

Recommendations

- After organ transplantation, screening for hyperglycemia should be done. A formal diagnosis of posttransplantation diabetes mellitus (PTDM) is best made once the individual is stable on an immunosuppressive plan and in the absence of an acute infection. **B**
- The OGTT is the preferred test to make a diagnosis of PTDM. **B**
- Immunosuppressive plans shown to provide the best outcomes for individuals and graft survival should be used, irrespective of PTDM risk. **E**

MONOGENIC DIABETES SYNDROMES

Recommendations

- Regardless of current age, all people diagnosed with diabetes in the first 6 months of life should have genetic testing for neonatal diabetes. **A**
- Children and young adults who do not have typical characteristics of type 1 or type 2 diabetes and have a family history of diabetes in successive generations (suggestive of an autosomal-dominant pattern of inheritance) should have genetic testing for maturity-onset diabetes of the young (MODY). **A**
- In both instances, consultation with a center specializing in diabetes genetics is recommended to understand the significance of genetic mutations and how best to approach further evaluation, treatment, and genetic counseling. **E**

GESTATIONAL DIABETES MELLITUS

Recommendations

- In individuals who are planning pregnancy, screen those with risk factors B and consider testing all individuals of childbearing potential for undiagnosed prediabetes or diabetes. **E**
- Before 15 weeks of gestation, test individuals with risk factors B and consider testing all individuals E for undiagnosed diabetes at the first prenatal visit using standard diagnostic criteria if not screened preconception.
- Before 15 weeks of gestation, screen for abnormal glucose metabolism (defined as A1C 5.9–6.4% [41–47 mmol/mol] or FPG 110–125 mg/dL [6.1–6.9 mmol/L]) to identify individuals who are at higher risk of adverse pregnancy and neonatal outcomes and are at high risk of a later gestational diabetes mellitus (GDM) diagnosis. **B**
- Screen for GDM at 24–28 weeks of gestation in pregnant individuals not previously found to have diabetes or high-risk abnormal glucose metabolism detected earlier in the current pregnancy. **A**
- Screen individuals with GDM for prediabetes or diabetes at 4–12 weeks postpartum, using the 75-g OGTT and clinically appropriate nonpregnancy diagnostic criteria. **B**
- Individuals with a history of GDM should have lifelong screening for the development of prediabetes or diabetes every 1–3 years. **B**

Table 4: Screening for and diagnosis of GDM

One-step strategy
Perform a 75-g OGTT, with plasma glucose measurement when an individual is fasting and at 1 and 2 h, at 24–28 weeks of gestation in individuals not previously diagnosed with diabetes.
The OGTT should be performed in the morning after an overnight fast of at least 8 h.
The diagnosis of GDM is made when any of the following plasma glucose values are met or exceeded: • Fasting: 92 mg/dL (5.1 mmol/L) • 1 h: 180 mg/dL (10.0 mmol/L) • 2 h: 153 mg/dL (8.5 mmol/L)
Two-step strategy
Step 1:
Perform a 50-g GLT (nonfasting), with plasma glucose measurement at 1 h, at 24–28 weeks of gestation in individuals not previously diagnosed with diabetes.
If the plasma glucose level measured 1 h after the load is ≥130, 135, or 140 mg/dL (7.2, 7.5, or 7.8 mmol/L, respectively),* proceed to a 100-g OGTT.
Step 2:
The 100-g OGTT should be performed when the individual is fasting.
The diagnosis of GDM is made when at least two>† of the following four plasma glucose levels (measured fasting and at 1, 2, and 3 h during OGTT) are met or exceeded (Carpenter-Coustan criteria [208]): • Fasting: 95 mg/dL (5.3 mmol/L) • 1 h: 180 mg/dL (10.0 mmol/L) • 2 h: 155 mg/dL (8.6 mmol/L) • 3 h: 140 mg/dL (7.8 mmol/L)

GDM, gestational diabetes mellitus; GLT, glucose load test; OGTT, oral glucose tolerance test. *American College of Obstetricians and Gynecologists (ACOG) recommends any of the commonly used thresholds of 130, 135, or 140 mg/dL for the 1-h 50-g GLT. †ACOG notes that one elevated value can be used for diagnosis.

2. PREVENTION OR DELAY OF DIABETES AND ASSOCIATED COMORBIDITIES: STANDARDS OF CARE IN DIABETES–2026

Diabetes Care 2026;49(Suppl. 1):S50–S60

Recommendations

- In people with prediabetes, monitor for the development of diabetes at least annually; modify frequency of testing based on individual risk assessment. **E**
- In people with presymptomatic type 1 diabetes, monitor for disease progression using A1C approximately every 6 months and 75-g oral glucose tolerance test (i.e., fasting and 2-h plasma glucose) annually; modify frequency of monitoring and consider augmenting with other glycemic assessment tools such as continuous glucose monitoring metrics based on individual risk assessment incorporating age, number and type of autoantibodies, and glycemic metrics. **E**

LIFESTYLE BEHAVIOR CHANGE FOR TYPE 2 DIABETES PREVENTION

Recommendations

- Refer adults with overweight or obesity at high risk of type 2 diabetes to a diabetes prevention program to achieve and maintain a weight reduction of at least 5–7% of initial body weight through a healthy reduced-calorie eating pattern and ≥150 min/week of moderate-intensity physical activity. **A**
- Prescribe an evidence-based eating pattern (e.g., Mediterranean, low carbohydrate) to individuals with prediabetes to prevent type 2 diabetes. **B**
- Offer diabetes prevention programs to adults at high risk for type 2 diabetes. A Diabetes prevention programs should be covered by thirdparty payors, and inconsistencies in access should be addressed. **E**
- Based on individual preference, certified technology-assisted diabetes prevention programs through smartphones, web-based applications, and telehealth can be effective in preventing type 2 diabetes and should be considered. **B**

PHARMACOLOGIC INTERVENTIONS TO DELAY TYPE 2 DIABETES

Recommendations

- Metformin for the prevention of type 2 diabetes should be considered in adults at high risk of type 2 diabetes, as typified by the Diabetes Prevention Program, especially those aged 25–59 years with BMI ≥35 kg/m2, higher fasting plasma glucose (e.g., ≥110 mg/dL [≥6 mmol/L]), and higher A1C (e.g., ≥6.0% [≥42 mmol/mol]), and in individuals with prior gestational diabetes mellitus. **A**
- Consider using metformin to prevent hyperglycemia in high-risk individuals treated with a phosphatidylinositol 3-kinase α (PI3Kα) inhibitor (e.g., alpelisib and inavolisib). **B**
- Consider using metformin to prevent hyperglycemia in high-risk individuals treated with high-dose glucocorticoids. **B**
- Consider periodic assessment of vitamin B12 levels in individuals receiving long-term metformin therapy, especially in those with anemia or peripheral neuropathy. **B**

PREVENTION OF VASCULAR DISEASE AND MORTALITY

Recommendations

- Prediabetes is associated with heightened cardiovascular risk; therefore, screening for and treatment of modifiable risk factors for cardiovascular disease are suggested. **B**
- Statin therapy may increase the risk of type 2 diabetes in people at high risk of developing type 2 diabetes. In such individuals, glucose status should be monitored regularly and diabetes prevention approaches reinforced. It is not recommended that statins be avoided or discontinued for this adverse effect. **B**
- In people with a history of stroke and evidence of insulin resistance and prediabetes, pioglitazone may be considered to lower the risk of stroke or myocardial infarction. However, this benefit needs to be balanced with the increased risk of weight gain, edema, and fractures. **A** Lower doses may mitigate the risk of adverse effects but may be less effective. **C**

PERSON-CENTERED CARE GOALS

Recommendations

- In adults with overweight or obesity at high risk of type 2 diabetes, care goals should include weight loss and maintenance, minimizing the progression of hyperglycemia, and attention to cardiovascular risk. **B**
- Pharmacotherapy (e.g., for weight management, minimizing the progression of hyperglycemia, and cardiovascular risk reduction) should be considered to support personcentered care goals. **A**
- More intensive preventive approaches should be considered in individuals who are at particularly high risk of progression to diabetes, including individuals with BMI ≥35 kg/m2, those with higher glucose levels (e.g., fasting plasma glucose 110–125 mg/dL [6.1–6.9 mmol/L], 2-h postchallenge glucose 173–199 mg/dL [9.6–11.0 mmol/L], and A1C ≥6.0% [≥42 mmol/mol]), and individuals with a history of gestational diabetes mellitus. **A**

3. COMPREHENSIVE MEDICAL EVALUATION AND ASSESSMENT OF COMORBIDITIES: STANDARDS OF CARE IN DIABETES–2026

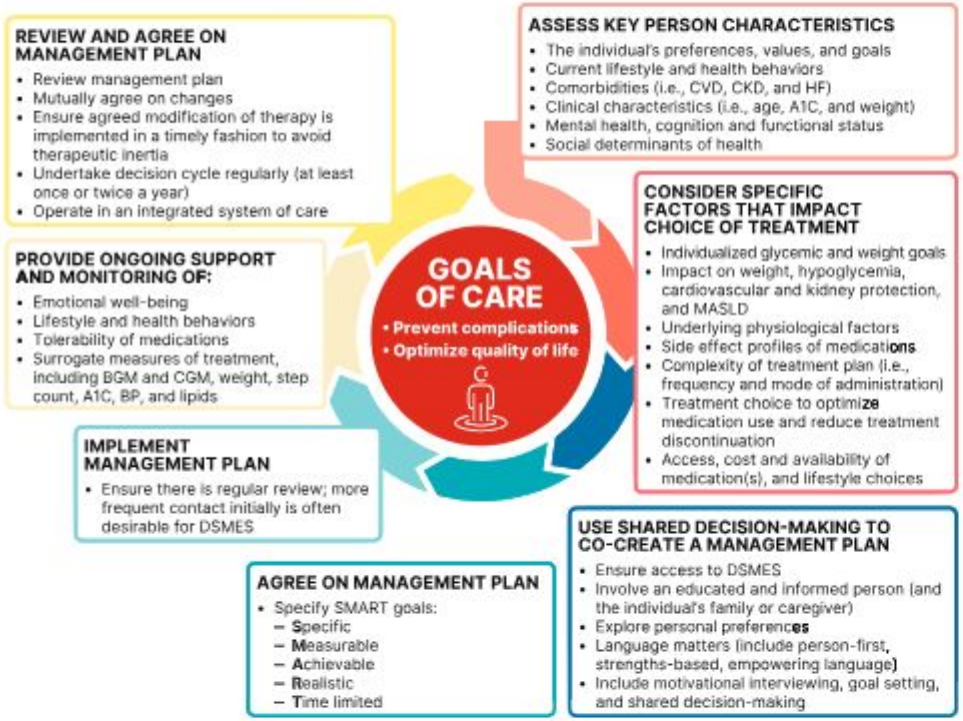
PERSON-CENTERED COLLABORATIVE CARE

Diabetes Care 2026;49(Suppl. 1):S61–S88

Recommendations

- A communication style that uses person-centered, culturally sensitive, and strength-based language and active listening; elicits individual preferences and beliefs; and assesses literacy, numeracy, and potential barriers to care should be used to optimize health outcomes and health-related quality of life. **B**
- People with diabetes can benefit from a coordinated interprofessional team that may include but is not limited to diabetes care and education specialists, primary care and subspecialty clinicians, nurses, registered dietitian nutritionists, exercise specialists, pharmacists, dentists, podiatrists, and behavioral health professionals. **C**

Figure 1: Decision cycle for person-centered glycemic 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.

COMPREHENSIVE MEDICAL EVALUATION

Recommendations

- A complete medical evaluation should be performed at the initial visit and follow-up, as appropriate, to:
  - Confirm the diagnosis and classify diabetes. **A**
  - Assess glycemic status and previous and current treatment. **A**
  - Evaluate for diabetes complications, potential comorbid conditions, and overall health status. **A**
  - Identify care partners, support systems, and available resources. **E**
  - Assess social determinants of health and structural barriers to optimal health and health care. **A**
  - Review risk factor management in the person with diabetes. **A**
  - Begin engagement with the person with diabetes in the formulation of a care management plan including goals of care. **A**
  - Develop a plan for continuing care. **A**
- Ongoing management should be guided by the assessment of overall health and functional status, diabetes complications, cardiovascular risk, hypoglycemia risk, and shared decision making to set therapeutic goals. **B**

IMMUNIZATIONS

Recommendations

- Provide routinely recommended vaccinations for children, adolescents, and adults with diabetes as indicated by age. **A**

Table 5: Components of the comprehensive diabetes medical evaluation at initial, follow-up, and annual visits

	Visit		
	Initial	Every follow-up	Annual
Past medical and family history			
Diabetes history			
• Characteristics at onset (e.g., age and symptoms and/or signs)	✓		
• Review of previous treatment plans and response	✓		
• Assess frequency, cause, and severity of past hospitalizations	✓		
Family history			
• Family history of diabetes in a first-degree relative	✓		
• Family history of autoimmune disorders	✓		
Personal history of complications and common comorbidities			
• Common comorbidities (e.g., obesity, OSA, and MASLD)	✓		✓
• High blood pressure or abnormal lipids	✓		✓
• Macrovascular and microvascular complications	✓		✓
• Hypoglycemia: awareness, frequency, causes, and timing of episodes	✓	✓	✓
• Presence of hemoglobinopathies or anemias	✓		✓
• Last dental visit	✓		✓
• Last foot exam	✓		✓
• Last dilated eye exam	✓		✓
• Visits to specialists	✓		
• Disability assessment and use of assistive devices (e.g., physical, cognitive, vision and auditory, history of fractures, and podiatry)	✓	✓	✓

	Visit		
	Initial	Every follow-up	Annual
• Personal history of autoimmune disease	✓		
Surgical and procedure history			
• Surgeries (e.g., metabolic surgery and transplantation)	✓	✓	✓
Interval history			
• Changes in medical or family history since last visit		✓	✓
Behavioral factors			
• Physical activity, sleep behaviors, eating patterns and weight history	✓	✓	✓
• Assess familiarity with carbohydrate counting (e.g., type 1 diabetes or type 2 diabetes treated with MDI)	✓		✓
• Screen for OSA	✓	✓	✓
• Tobacco, alcohol, and substance use	✓		✓
Medications and vaccinations			
• Current medication plan	✓	✓	✓
• Medication-taking behavior, including rationing of medications and/or medical equipment	✓	✓	✓
• Medication intolerance or side effects	✓	✓	✓
• Complementary and alternative medicine use	✓	✓	✓
• Vaccination history and needs	✓		✓
Technology use			
• Assess use of health apps, online education, patient portals, etc.	✓	✓	✓
• Glucose monitoring (meter/CGM): results and data use	✓	✓	✓
• Review insulin pump settings and use and connected pen and glucose data	✓	✓	✓
Social life assessment			
Social network			
• Identify existing social supports	✓		✓
• Identify surrogate decision maker and advanced care plan	✓		✓
• Identify social determinants of health (e.g., food security, housing stability, transportation access, financial security, and community safety)	✓		✓
• Assess daily routine and environment, including school or work schedules and ability to engage in diabetes self-management	✓	✓	✓
Physical examination			
• Height, weight, and BMI; growth and pubertal development in children and adolescents	✓	✓	✓
• Blood pressure determination	✓	✓	✓
• Orthostatic blood pressure measures (when indicated)	✓		✓
• Fundoscopic examination (refer to eye specialist)	✓		✓
• Thyroid palpation	✓		✓
• Skin examination (e.g., acanthosis nigricans, insulin injection or insertion sites, and lipodystrophy)	✓	✓	✓
• Comprehensive foot examination, determination of temperature, vibration or pinprick sensation, and 10-g monofilament exam	✓		✓
• Visual inspection (e.g., skin integrity, callous formation, foot deformity or ulcer, and toenails)*	✓	✓	✓
• Check pedal pulses and screen for PAD with ABI testing if a PAD diagnosis would change management	✓		✓
• Screen for depression, anxiety, diabetes distress, fear of hypoglycemia, and disordered eating	✓		✓
• Assessment for cognitive performance if indicated	✓		✓
• Assessment for functional performance if indicated	✓		✓
• Assessment for bone health (e.g., loss of height and kyphosis)	✓		✓
Laboratory evaluation			
• A1C, if the results are not available within the past 3 months or if earlier assessment is necessary	✓	✓	✓
• Lipid profile, including total, LDL, and HDL cholesterol and triglycerides‡	✓		
• Liver function tests (i.e., FIB-4)‡	✓		✓
• Spot urinary albumin-to-creatinine ratio	✓		✓
• Serum creatinine and estimated glomerular filtration rate§	✓		✓
• Thyroid-stimulating hormone in people with type 1 diabetes‡	✓		✓
• Celiac disease screening in people with type 1 diabetes‖	✓		
• Vitamin B12 if taking metformin for >5 years	✓		✓
• CBC with platelets	✓		✓
• Serum potassium levels in people treated with ACE inhibitors, ARBs, or diuretics§	✓		✓
• Calcium, vitamin D, and phosphorous as appropriate	✓		✓

ABI, ankle brachial index; ARBs, angiotensin receptor blockers; CBC, complete blood count; CGM, continuous glucose monitor; FIB-4, fibrosis-4 index; MASLD, metabolic-associated steatotic liver disease; MDI, multiple daily injections; OSA, obstructive sleep apnea; PAD, peripheral arterial disease. *Should be performed at every visit in people with diabetes with sensory loss, previous foot ulcers, or amputations. †At 65 years of age or older. ‡May also need to be checked after initiation or dose changes of medications that affect these laboratory values (i.e., diabetes medications, blood pressure medications, cholesterol medications, or thyroid medications). §May be needed more frequently in people with diabetes with known chronic kidney disease or with changes in medications that affect kidney function and serum potassium. In people with presence of gastrointestinal symptoms, signs, laboratory manifestations, or clinical suspicion suggestive of celiac disease

ESSENTIAL COMPONENTS FOR ASSESSMENT, PLANNING, AND REFERRAL*

Assessing risk of diabetes complications

- ASCVD and heart failure history
- ASCVD risk factors and 10-year ASCVD risk assessment
- Staging of chronic kidney disease
- Hypoglycemia risk
- Assessment for retinopathy
- Assessment for neuropathy
- Assessment for MASLD and MASH

Goal setting

- Set A1C, blood glucose, and time-in-range goals
- Set lipid goal
- If hypertension is present, establish blood pressure goal
- Weight management and physical activity goals
- Diabetes self-management goals

Therapeutic treatment plans

- Lifestyle management (e.g., registered dietitian nutritionist)
- Pharmacologic therapy: glucose lowering
- Pharmacologic therapy: cardiovascular and kidney disease risk factors
- Weight management with pharmacotherapy or metabolic surgery, as appropriate
- Use of glucose monitoring and insulin delivery devices
- Referral to diabetes education and medical specialists (as needed)

Referrals for initial care management

- Eye care professional for annual dilated eye exam
- Family planning for individuals of childbearing potential
- Registered dietitian nutritionist for medical nutrition therapy
- Diabetes self-management education and support
- Dentist for comprehensive dental and periodontal examination
- Behavioral health professional, if indicated
- Audiology, if indicated
- Social worker and community resources, if indicated
- Rehabilitation medicine or another relevant health care professional for physical and cognitive disability evaluation, if indicated
- Other appropriate health care professionals

Assessment and treatment planning are essential components of initial and all follow-up visits. ASCVD, atherosclerotic cardiovascular disease; MASH, metabolic dysfunction-associated steatohepatitis; MASLD, metabolic dysfunction-associated steatotic liver disease.

Table 6: Highly recommended immunizations for adults with diabetes (from the Advisory Committee on Immunization Practices and Centers for Disease Control and Prevention).

Vaccine	Recommended ages	Schedule	GRADE evidence type*	References
COVID-19	All people 6 months of age and older	Current initial vaccination and boosters	3	Centers for Disease Control and Prevention, Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States (305)
Hepatitis B	Adults with diabetes aged <60 years; for adults aged ≥60 years, hepatitis B vaccine may be administered at the discretion of the treating clinician based on the person's likelihood of acquiring hepatitis B infection		1	Sandul et al., Updated Recommendation for Universal Hepatitis B Vaccination in Adults Aged 19–59 Years - United States, 2024 (306)
Influenza	All people with diabetes advised to receive a trivalent influenza vaccine and not to receive live attenuated influenza vaccine	Annual	3	Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger - United States, 2025, and Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older - United States, 2025 (6,7)
Pneumonia (PPSV23 [Pneumovax])	19–64 years of age, vaccinate with Pneumovax	One dose is recommended for those who previously received PCV13; if PCV15 was used, follow with PPSV23 ≥1 year later; PPSV23 is not indicated after PCV20; adults who received only PPSV23 may receive PCV15 or PCV20 ≥1 year after their last dose	2	Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger - United States, 2025, and Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older - United States, 2025 (6,7)
	≥65 years of age	One dose is recommended for those who previously received PCV13; if PCV15 was used, follow with PPSV23 ≥1 year later; PPSV23 is not indicated after PCV20; adults who received only PPSV23 may receive PCV15 or PCV20 ≥1 year after their last dose	2	Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger - United States, 2025, and Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older - United States, 2025 (6,7)
PCV20 or PCV15	Adults 19–64 years of age with an immunocompromising condition (e.g., chronic renal failure), cochlear implant, or cerebrospinal fluid leak Adults 19–64 years of age, immunocompetent ≥65 years of age, immunocompetent, have shared decision-making discussion with health care professionals	One dose of PCV15 or PCV20 is recommended by the Centers for Disease Control and Prevention For those who have never received any pneumococcal vaccine, the Centers for Disease Control and Prevention recommends one dose of PCV15 or PCV20 One dose of PCV15 or PCV20; PCSV23 may be given ≥8 weeks after PCV15; PPSV23 is not indicated after PCV20	2	Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger - United States, 2025, and Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older - United States, 2025 (6,7)
RSV	Older adults ≥60 years of age with diabetes appear to be a risk group	Adults aged ≥75 years and those aged ≥60 years and at high risk may receive a single dose of an RSV vaccine	1	Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger - United States, 2025, and Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older - United States, 2025 (6,7)
Tetanus, diphtheria, pertussis (Tdap)	All adults; pregnant individuals should have an extra dose	Booster every 10 years	2	Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger - United States, 2025,

				and Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older - United States, 2025 (6,7)
Zoster	≥50 years of age	Two-dose Shingrix, even if previously vaccinated	1	Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger - United States, 2025, and Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older - United States, 2025 (6,7)

For a comprehensive list of vaccines, refer to the Centers for Disease Control and Prevention web site at cdc.gov/vaccines/. Advisory Committee on Immunization Practices recommendations can be found at cdc.gov/acip/?CDC_AAref_Val=https://cdc.gov/vaccines/acip/recommendations. COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; PCV13, 13-valent pneumococcal conjugate vaccine; PCV15, 15-valent pneumococcal conjugate vaccine; PCV 20, 20-valent pneumococcal conjugate vaccine; PPSV23, 23-valent pneumococcal polysaccharide vaccine; RSV, respiratory syncytial virus. *Evidence type: 1, randomized controlled trials (RCTs) or overwhelming evidence from observational studies; 2, RCTs with important limitations or exceptionally strong evidence from observational studies; 3, observational studies or RCTs with notable limitations; 4, clinical experience and observations, observational studies with important limitations, or RCTs with several major limitations.

ASSESMENT OF COMORBIDITIES

Autoimmune Diseases

Recommendations

- Screen people with type 1 diabetes for autoimmune thyroid disease soon after diagnosis and thereafter at repeated intervals if clinically indicated. **B**
- Adults with type 1 diabetes should be screened for celiac disease in the presence of gastrointestinal symptoms, signs, laboratory manifestations, or clinical suspicion suggestive of celiac disease. **B**

Bone Health

Recommendations

- Assess fracture risk in older adults with diabetes as a part of routine care in diabetes clinical practice, according to risk factors and comorbidities. **A**
- Monitor bone mineral density using dual-energy X-ray absorptiometry in older adults with diabetes (aged ≥65 years) and younger individuals with diabetes and multiple risk factors every 2–3 years. **A**
- Consider the potential adverse impact on skeletal health when selecting pharmacological options to lower glucose levels in people with diabetes. Avoiding medications with a known association with higher fracture risk (e.g., thiazolidinediones and sulfonylureas) is recommended, particularly for those at elevated risk for fractures. **B**
- To reduce the 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**
- Advise people with diabetes on their intake of calcium (1,000–1,200 mg/day) and vitamin D to ensure it meets the recommended daily allowance for those at risk for fracture, either through their food choices or supplemental means. **B**
- Consider osteoporosis drug therapy in older adults with diabetes who are at increased risk of fracture, including those with low bone mineral density (T-score ≤−2.5), history of fragility fracture, or elevated Fracture Risk Assessment Tool score (≥3% for hip fracture or ≥20% for major osteoporotic fracture). **B**
- 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**

Cognitive Impairment/Dementia

Recommendations

- In the presence of cognitive impairment, diabetes treatment plans should be simplified as much as possible and tailored to minimize the risk of hypoglycemia. **B**

Metabolic Dysfunction–Associated Steatotic Liver Disease and Metabolic Dysfunction–Associated Steatohepatitis

Screening

Recommendations

- Screen adults with type 2 diabetes or with prediabetes, particularly those with obesity or other cardiometabolic risk factors or established cardiovascular disease, for their risk of having or developing cirrhosis related to metabolic dysfunction associated steatohepatitis (MASH) using a calculated fibrosis-4 index (FIB-4) (derived from age, ALT, AST, and platelets [mdcalc.com/calc/2200/fibrosis4-fib-4-index-liver-fibrosis]), even if they have normal liver enzymes. **B**
- Adults with diabetes or prediabetes with persistently elevated plasma aminotransferase levels for >6 months and low FIB-4 should be evaluated for other causes of liver disease. **B**
- Adults with type 2 diabetes or prediabetes with a FIB-4 ≥ 1.3 should have additional risk stratification by liver stiffness measurement with transient elastography, or, if unavailable, the enhanced liver fibrosis (ELF) test. **B**
- Refer adults with type 2 diabetes or prediabetes at higher risk for significant liver fibrosis (i.e., as indicated by FIB-4, liver stiffness measurement, or ELF) to a gastroenterologist or hepatologist for further evaluation and management. **B**

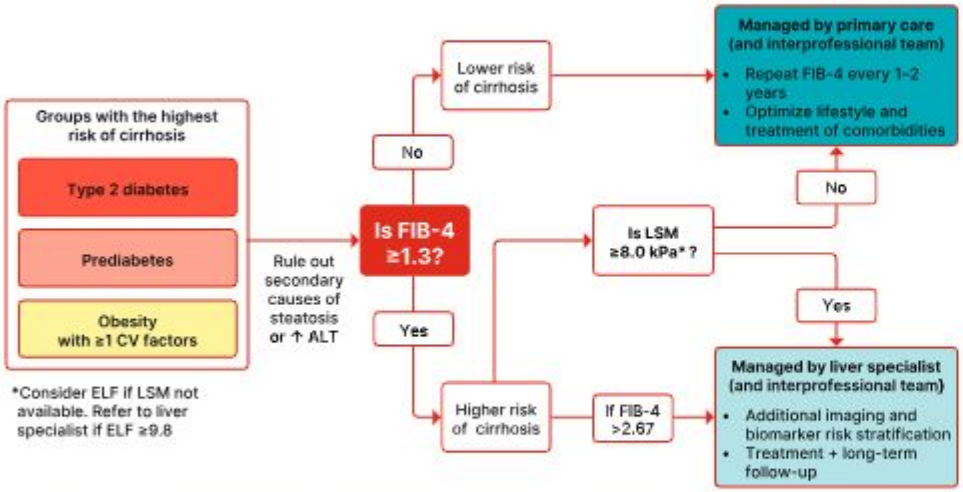
Management

Recommendations

- Adults with type 2 diabetes or prediabetes, particularly with overweight or obesity, who have metabolic dysfunction–associated steatotic liver disease (MASLD) should be recommended lifestyle changes using an interprofessional approach that promotes weight loss, ideally within a structured nutrition plan and physical activity program for cardiometabolic benefits **B** and histological improvement. **C**
- In adults with type 2 diabetes, MASLD, and overweight or obesity, consider using a glucagon-like peptide 1 receptor agonist (GLP-1 RA) with demonstrated benefits in MASH A or a dual glucose-dependent insulinotropic polypeptide (GIP) and GLP-1 RA with potential benefits in MASH **B** for the treatment of obesity as an adjunctive therapy to lifestyle interventions for weight loss.
- In adults with type 2 diabetes and biopsy-proven MASH or those at high risk for liver fibrosis (based on noninvasive tests), a GLP-1 RA is preferred for glycemic management due to beneficial effects on MASH. **A** Pioglitazone **B** or a dual GIP and GLP-1 RA **B** can be considered for glycemic management due to potential beneficial effects on MASH.

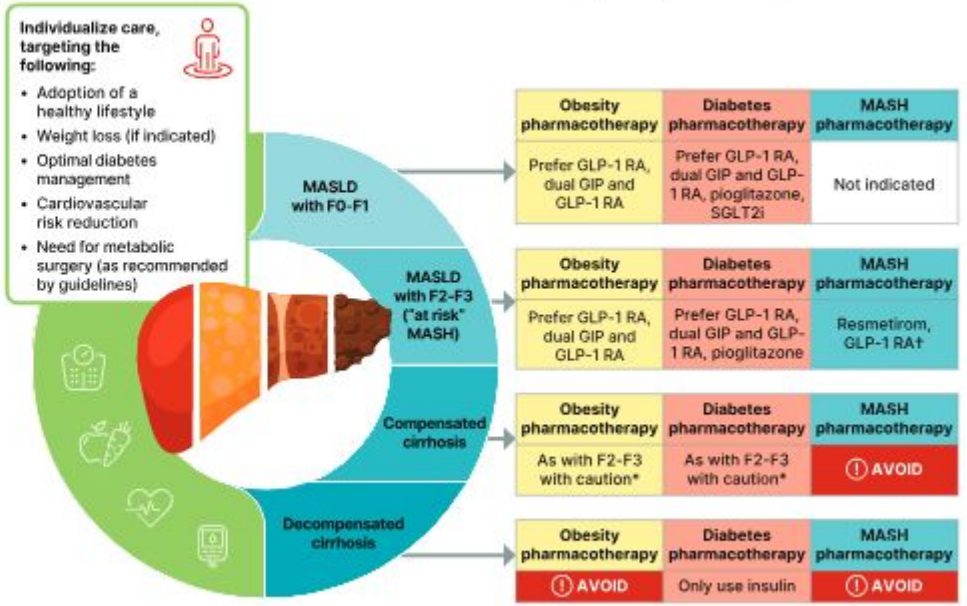
- Combination therapy with pioglitazone plus GLP-1 RA can be considered for the treatment of hyperglycemia in adults with type 2 diabetes with biopsy-proven MASH or those at high risk of liver fibrosis (identified with noninvasive tests) because of potential beneficial effects on MASH. **B**
- For consideration of treatment with a thyroid hormone receptor-β agonist in adults with type 2 diabetes or prediabetes with MASLD with moderate (F2) or advanced (F3) liver fibrosis on liver histology, or by a validated imaging-based or blood-based test, refer to a gastroenterologist or hepatologist with expertise in MASLD management. **A**
- Treatment initiation and monitoring should be individualized and within the context of an interprofessional team that includes a gastroenterologist or hepatologist, consideration of individual preferences, and a careful shared-decision cost-benefit discussion. **B**
- In adults with type 2 diabetes and MASLD, use of glucose-lowering therapies other than pioglitazone or GLP-1 RAs may be continued as clinically indicated, but these therapies lack evidence of benefit in MASH. **B**
- Insulin therapy is the preferred agent for the treatment of hyperglycemia in adults with type 2 diabetes with decompensated cirrhosis. **C**
- Adults with type 2 diabetes and MASLD are at increased cardiovascular risk; therefore, comprehensive management of cardiovascular risk factors is recommended. **B**
- Statin therapy is safe in adults with type 2 diabetes and compensated cirrhosis from MASLD and should be initiated or continued for cardiovascular risk reduction as clinically indicated. B In people with decompensated cirrhosis, statin therapy should be used with caution, and close monitoring is needed, given limited safety and efficacy data. **B**
- Consider metabolic surgery in appropriate candidates as an option to treat MASH in adults with type 2 diabetes and obesity B and to improve cardiovascular outcomes. **B**
- Metabolic surgery should be used with caution in adults with type 2 diabetes with compensated cirrhosis from MASLD B and is not recommended in decompensated cirrhosis. **B**

Figure 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.

Figure 3: 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.
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.

4. FACILITATING POSITIVE HEALTH BEHAVIORS AND WELL-BEING TO IMPROVE HEALTH OUTCOMES: STANDARDS OF CARE IN DIABETES–2026

Diabetes Care 2026;49(Suppl. 1):S89–S131

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT

Recommendations

- Advise all people with diabetes to participate in developmentally and culturally appropriate diabetes self-management education and support (DSMES) to facilitate informed decision-making, self-care behaviors, problem-solving, and active collaboration with the health care team. **A**
- Provide DSMES at diagnosis, annually and/or when not meeting treatment goals, when complicating factors develop (e.g., medical, functional, and psychosocial), and when transitions in life and care occur. **E**
- Assess clinical outcomes, health status, and well-being as key goals of DSMES on an individualized timeframe. **C**
- Use behavioral strategies (e.g., motivational interviewing, goal setting, problem-solving) to support DSMES and engagement in behaviors known to optimize health-related quality of life and outcomes. **A**
- Provide culturally and socially appropriate DSMES responsive to personal preferences and needs in group or individual settings. A Communicate DSMES participation with the diabetes care team. **E**
- Offer DSMES via telehealth and/or digital interventions to meet individual preferences, reduce access barriers, and improve satisfaction. **B**
- DSMES can improve outcomes and reduce costs, so reimbursement by third-party payors is recommended. **B**
- Identify and address barriers to DSMES that exist at the payor, health system, clinic, health care professional, and individual levels. **E**
- Assess the social determinants of health to guide and design delivery of DSMES to maximize health equity across populations. **C**

Nutrition recommendations

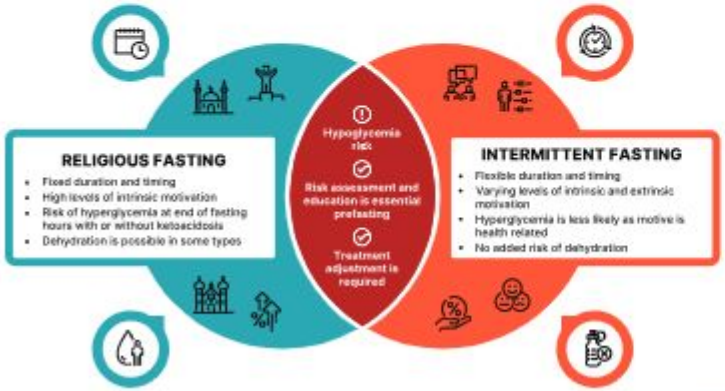
- Provide individualized medical nutrition therapy by referring people with prediabetes or diabetes to a registered dietitian nutritionist, preferably one who has comprehensive experience in diabetes care. **A**
- Diabetes medical nutrition therapy can result in cost savings **B** and improved cardiometabolic outcomes A and should be reimbursed by insurance. **E**
- Provide an overweight or obesity treatment plan based on their nutrition, physical activity, and behavioral health status for all people with overweight or obesity, aiming for at least 5–7% weight loss. **A**
- For diabetes prevention and management of people with prediabetes or diabetes, recommend individualized meal plans that keep nutrient quality, total calories, and metabolic goals in mind. **B**
- Eating patterns should emphasize key nutrition principles (inclusion of nonstarchy vegetables, whole fruits, legumes, lean proteins, whole grains, nuts and seeds, and low-fat dairy or nondairy alternatives) and minimize consumption of red meat, sugar-sweetened beverages, sweets, refined grains, processed and ultraprocessed foods in people with prediabetes and diabetes. **B**
- Consider reducing carbohydrate intake for some adults with diabetes to improve glycemia. An effective way to achieve this is by limiting consumption of processed foods. **B**
- Assess intake of supplements, as supplementation with micronutrients (e.g., vitamins and minerals, such as magnesium or chromium) or herbs or spices (e.g., cinnamon and aloe vera) is not recommended for glycemic benefits. **C**
- Counsel against β-carotene supplementation, as there is evidence of harm for certain individuals and it confers no benefit. **B**
- Advise adults with diabetes and those at risk for diabetes who consume alcohol to not exceed the recommended daily limits. B Advise abstainers to not start drinking alcohol, even in moderation. **B**
- Counsel people with diabetes about the signs, symptoms, and self-management of delayed hypoglycemia and the importance of monitoring glucose after drinking alcohol to reduce hypoglycemia risk, especially when using insulin or insulin secretagogues. **B**
- Counsel people with diabetes to limit sodium consumption to <2,300 mg/day, as clinically appropriate, and the best way to achieve this is through limiting consumption of processed foods. **B**
- Encourage people with diabetes and those at risk for diabetes to consume water over other beverages. **A**
- Counsel people with diabetes and those at risk for diabetes that nonnutritive sweeteners can be used in place of sugar-sweetened products if consumed in moderation and for the short term to reduce overall calorie and carbohydrate intake. **B**
- Counsel and regularly monitor individuals pursuing intentional weight loss to ensure adequate nutritional intake, with particular attention to preventing protein insufficiency and micronutrient deficiencies. **E**
- Emphasize minimally processed, nutrient-dense, high-fiber sources of carbohydrate (at least 14 g fiber per 1,000 kcal). **B**
- Advise people with diabetes and those at risk for diabetes to replace sugar-sweetened beverages (including any juices) with water or low-calorie or no-calorie beverages and minimize foods with added sugar to manage glycemia and reduce risk for cardiometabolic disease. **B**
- Educate individuals with diabetes who are at risk for developing diabetic ketoacidosis and who are treated with sodium–glucose cotransporter inhibition on the risks and signs of ketoacidosis and methods of risk mitigation management, provide them with appropriate tools for ketone measurement (i.e., serum β-hydroxybutyrate), and discourage a ketogenic eating pattern. **E**
- Provide education on the glycemic impact of carbohydrate, **A** fat, and protein **B** tailored to an individual's needs, insulin plan, and preferences for care to optimize mealtime insulin dosing.
- Counsel people using fixed insulin doses about consistent patterns of carbohydrate intake with respect to time and amount while considering the insulin action time, as it can result in improved glycemia and reduce the risk for hypoglycemia. **B**
- Counsel people with diabetes and those at risk for diabetes to incorporate more plant-based protein sources (e.g., nuts, seeds, and legumes) as part of an overall diverse eating pattern to reduce cardiovascular disease risk. **B**
- Counsel people with diabetes and those at risk for diabetes to consider an eating plan emphasizing elements of a Mediterranean eating pattern, which is rich in fatty fish, nuts, and seeds, to reduce cardiovascular disease risk **A** and improve glucose metabolism. **B**
- Counsel people with diabetes and those at risk for diabetes to limit intake of foods high in saturated fat to help reduce cardiovascular disease risk. **B**

Nutrition behaviors to encourage

- Vegetables—especially nonstarchy vegetables that are dark green, red, and orange in color; fresh, frozen, or low-sodium canned are all acceptable vegetable options.
- Legumes—dried beans, peas, and lentils.
- Fruits—especially whole fruit—fresh, frozen, or canned in own juice (or no added sugar) are all acceptable fruit options.
- Foods with at least 3 g of fiber per serving are generally considered higher fiber choices. Whole-grain foods—where culturally appropriate, whole-grain versions of commonly consumed foods, such as 100% whole-wheat breads or pastas and brown rice. When not culturally appropriate, focus more on portion control.
- Water should be the primary beverage of choice.
- For individuals who do not prefer plain water, no-calorie alternatives are the next best choice. Options include adding lemon, lime, berries, or cucumber slices to water; sparkling no-calorie water or flavored no-calorie waters; no-calorie carbonated beverages.
- Plant-based proteins can include legumes (e.g., soybeans, pinto beans, black beans, garbanzo beans, dried peas, and lentils), nuts, and seeds.
- Meats and poultry should be from fresh, frozen, or low-sodium canned and in lean forms (e.g., chicken breast and ground turkey).
- Heart-healthy wild-caught fatty fish such as salmon, tuna, sardines, and mackerel. Fresh, frozen, or low-sodium canned are all acceptable options.
- Use herbs (e.g., basil, fennel, mint, parsley, rosemary, and thyme) and spices (e.g., cinnamon, garam masala, ginger, pepper, and turmeric) to season foods instead of salt or salt-containing preparations.
- Incorporate onions, garlic, celery, carrots, and other vegetables as a base for preparing various homemade foods.
- Cook with vegetable oil (e.g., avocado, canola, and olive) in place of fats high in saturated fat (e.g., butter, coconut oil, lard, and shortening).
- Plan out meals for the week. Grocery shop using a list. Cook on a day off so there are ready-to-eat and ready-to-reheat homemade meals waiting in the fridge or freezer.
- Include family or roommates in meal preparation; share the responsibilities of grocery shopping and cooking and use time off for meal preparation in advance when possible.

RELIGIOUS FASTING

Figure 4: Differences and similarities between religious and intermittent fasting for people with diabetes.



Recommendations

- Use the updated International Diabetes Federation along with Diabetes and Ramadan International Alliance comprehensive prefasting risk assessment to generate a risk score for the safety of religious fasting. Provide fasting-focused education to minimize risks. **B**
- 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 7: Changes in medications during fasting

Medication name	Risk of hypoglycemia	Timing	Total daily dose
Metformin, SGLT2 inhibitor, DPP-4 inhibitor, GLP-1 receptor agonist, acarbose, or pioglitazone	Low	If once daily, then take at main mealtime. If twice daily, then split dose between the two meals. If once weekly, no change of time.	No change
New generation of sulfonylurea (glimepiride and gliclazide)	Low to moderate	If once daily, then take at main mealtime. If twice daily, then split dose between the two meals.	Reduce dose if glucose levels are within individualized goal range and if no hypoglycemia or hyperglycemia is present at baseline.
Older generation of sulfonylurea (glyburide)	Moderate to high	Take at time of main meal	Replace with newer-generation sulfonylurea or reduce dose by 50%.
Basal insulin	Moderate to high	For longer-acting basal analogs (glargine 300 or degludec), no need to change timing. For other basal insulins, take at beginning of breaking fast meal.	Choose the insulin with lower risk of hypoglycemia among the class. Reduce dose by 25–35% if not well managed.
Prandial insulin	High	At mealtime	Reduce dose of insulin for the meal followed by fasting (35–50%). For other meals, insulin dose should match carbohydrate intake.
Mixed insulin and insulin coformulations	High	If once daily, then take at main mealtime. If twice daily, then split dose between the two meals	Reduce dose of insulin for the meal followed by fasting (35–50%). For other meals, no change of dose.

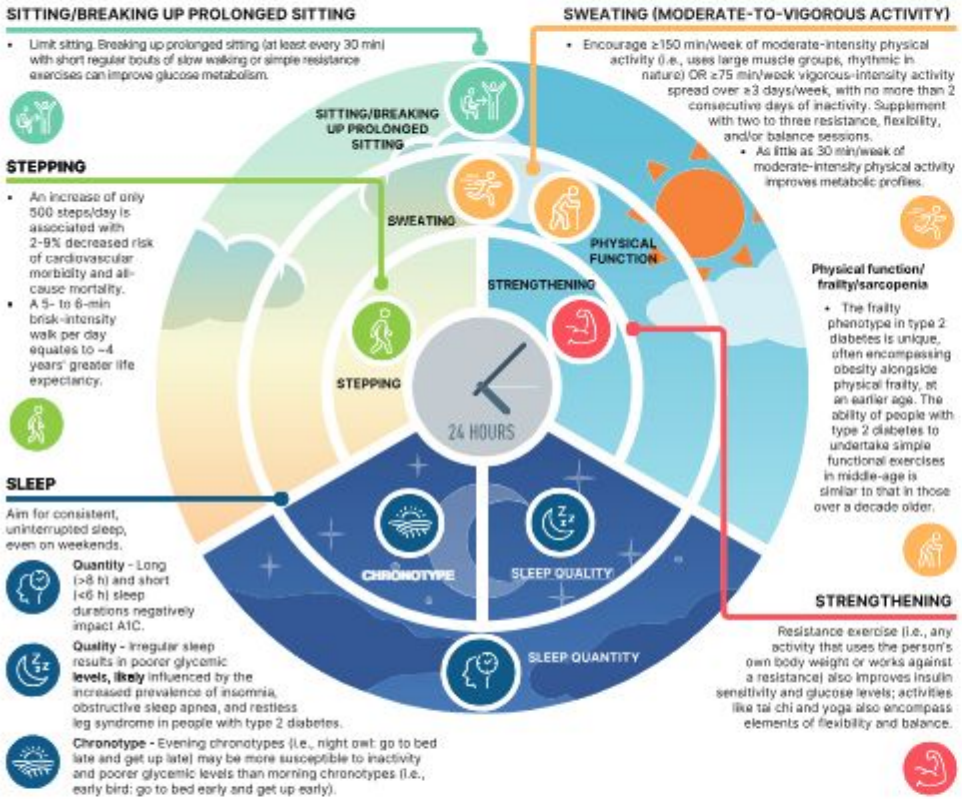
PHYSICAL ACTIVITY

Recommendations

- Evaluate baseline physical activity and sedentary time for all people with diabetes and those at risk for diabetes. For people who do not meet activity guidelines, encourage an increase in physical activities above baseline with the goal of meeting activity guidelines. **B** Counsel that prolonged sitting should be interrupted at least every 30 min for blood glucose and other benefits. **C**
- Counsel children and adolescents with type 1 diabetes **C** or type 2 diabetes **B** to engage in 60 min/day or more of moderate- or vigorous-intensity aerobic activity, with musclestrengthening and bone-strengthening activities at least 3 days/week, and to limit the amount of time being spent sedentary, including recreational screen time. **C**
- Counsel most adults with type 1 diabetes **C** and type 2 diabetes **B** to engage in 150 min or more of moderate- to vigorous-intensity aerobic activity per week, spread over at least 3 days/week, with no more than 2 consecutive days without activity. Shorter durations (minimum 75 min/week) of vigorous-intensity or interval training may be sufficient for more physically fit individuals.
- Counsel adults with type 1 diabetes **C** and type 2 diabetes **B** to engage in 2–3 sessions/week of resistance exercise on nonconsecutive days.

- Counsel most older adults with diabetes to engage in flexibility training and balance training 2–3 times/week. **C**
- Counsel all people with diabetes who are treated with obesity pharmacotherapy or metabolic surgery that meeting physical activity recommendations, in particular muscle-strengthening exercises, may be beneficial for maintaining lean body mass. **C**

Figure 5: Importance of 24-h physical behaviors for type 2 diabetes.



	Glucose/ insulin	Blood pressure	A1C	Lipids	Physical function	Depression	Quality of life
SITTING/BREAKING UP PROLONGED SITTING	🟢	🟡	🔴	🔴	🔴	🔴	🔴
STEPPING	🟢	🟡	🟡	🟡	🔴	🟢	🟢
SWEATING (MODERATE-TO-VIGOROUS ACTIVITY)	🟢	🟢	🟢	🟢	🟢	🟢	🟢
STRENGTHENING	🟢	🟡	🟢	🟡	🟢	🔴	🟡
ADEQUATE SLEEP DURATION	🟢	🔴	🟢	🔴	🔵	🟡	🟡
GOOD SLEEP QUALITY	🟢	🟢	🟢	🟢	🔵	🟡	🟢
CHRONOTYPE/CONSISTENT TIMING	🟡	🔵	🟡	🔵	🔵	🟡	🔵

IMPACT OF PHYSICAL BEHAVIORS ON CARDIOMETABOLIC HEALTH IN PEOPLE WITH TYPE 2 DIABETES

↑ Higher levels of improvement (physical function, quality of life) ↓ Lower levels of improvement (glucose/insulin, blood pressure, A1C, lipids, depression)
🔵 No data available
🟢 Green arrows = strong evidence 🟡 Yellow arrows = medium-strength evidence 🔴 Red arrows = limited evidence

SMOKING CESSATION: TOBACCO AND E-CIGARETTES, AND CANNABIS

Recommendations

- Ask people with diabetes routinely about the use of tobacco or vape products. **A** Advise complete avoidance of tobacco and vaping. **A** For individuals who use these products, provide or refer for combination treatment consisting of tobacco and/or vape product(s) cessation counseling and pharmacologic therapy. **A**
- Advise people with type 1 diabetes **C** and those with other forms of diabetes at risk for diabetic ketoacidosis not to use recreational cannabis in any form. **E**

PSYCHOSOCIAL CARE

Recommendations

- Provide psychosocial care to all people with diabetes as part of routine medical care delivered by trained health care professionals using a collaborative, person-centered, culturally informed approach. **A**
- Implement screening protocols for psychosocial concerns, preferably using age-appropriate standardized and validated tools. Screen at least annually or when there is a change in health status, treatment, or life circumstances. **C**
- Refer to behavioral health professionals or other trained health care professionals, ideally those with experience in diabetes, for further assessment and treatment of psychosocial concerns as indicated. **B**

Diabetes distress

Recommendations

- Screen for diabetes distress at least annually in people with diabetes, caregivers, and family members, and repeat screening when treatment goals are not met, at transitional times, and/or in the presence of diabetes complications. Health care professionals should consider referral to a qualified behavioral health professional, ideally one with experience in diabetes, for further assessment and treatment if not adequately addressed during medical appointments. **B**

Anxiety

Recommendations

- Screen for anxiety symptoms at least annually in people with diabetes. Health care professionals can address anxiety symptoms within the scope of their practice. Consider referral to a qualified behavioral health professional for further assessment and treatment if anxiety symptoms interfere with diabetes self-management behaviors or quality of life, if not adequately addressed during medical appointments. **B**
- Screen individuals at high risk for hypoglycemia or with severe and/or frequent hypoglycemia for fear of hypoglycemia at least annually and when clinically appropriate. **E** Refer to a trained health care professional for evidence-based intervention. **A**

Depression

Recommendations

- Screen for depressive symptoms in all people with diabetes at least annually and more frequently among those with a history of depression. **B** Refer to qualified behavioral health professionals or other health care professionals with experience using evidencebased treatment approaches for depression in collaboration with the diabetes care team. **A**
- Rescreen for depression at diagnosis of complications or when there are significant changes in medical status. **B**

Disordered Eating Behavior

Recommendations

- Screen for disordered or disrupted eating using validated screening measures. Review the medical treatment plan to identify potential treatment-related effects on hunger/caloric intake. **B**
- Reevaluate the treatment plan of people with diabetes who present with symptoms of disordered eating behaviors, an eating disorder, or disrupted patterns of eating, ideally in consultation with a qualified professional. **B**

Serious Mental Illness

Recommendations

- Provide an increased level of support for people with diabetes and serious mental illness through enhanced monitoring of and assistance with diabetes self-management behaviors. **B**
- Monitor changes in body weight, glycemia, and lipids in adolescents and adults with diabetes who are prescribed second-generation antipsychotic medications; adjust the treatment plan accordingly, if needed. **C**

Cognitive Capacity and Impairment

Recommendations

- Monitor cognitive capacity throughout the life span for all individuals with diabetes, particularly in those who have documented cognitive disabilities, those who experience severe hypoglycemia, very young children, and older adults. **B**
- Consider referral for a formal assessment if cognitive capacity changes or appears to be suboptimal for decision-making and/or behavioral selfmanagement. **E**

Sleep Health

Recommendations

- Screen for sleep health in people with prediabetes or diabetes and in those at risk for diabetes, including screening for sleep disorders and diabetes-related sleep disruptions. Refer to sleep medicine specialists and/or qualified behavioral health professionals or diabetes care team as indicated. **B**
- Counsel people with diabetes to practice sleep-promoting routines and habits. **A**

Situations that warrant referral of a person with diabetes to a qualified behavioral health professional for evaluation and treatment

- A positive screen on a validated screening tool for depressive symptoms, diabetes distress, anxiety, fear of hypoglycemia, suicidality, or cognitive impairment
- The presence of symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating
- Intentional omission or underdosing of insulin or noninsulin medication to cause weight loss
- A serious mental illness is suspected
- In children and adolescents and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, failure to achieve expected developmental milestones, or significant distress
- Low engagement in diabetes self-management behaviors, including declining or impaired ability to perform diabetes self-management behaviors
- Before undergoing metabolic surgery and after surgery, if assessment reveals an ongoing need for adjustment support

5. GLYCEMIC GOALS AND HYPOGLYCEMIA AND HYPERGLYCEMIC CRISES: STANDARDS OF CARE IN DIABETES–2026

ASSESSMENT OF GLYCEMIC CONTROL

Diabetes Care 2026;49(Suppl. 1):S132–S149

Glycemic Assessment

Recommendations

- Assess glycemic status by A1C A and/or continuous glucose monitoring (CGM) metrics such as time in range, time above range, and time below range. **B** Fructosamine or CGM can be used for glycemic monitoring when an alternative to A1C is required. **B**
- Assess glycemic status at least two times a year, and more frequently (e.g., every 3 months) for individuals not meeting glycemic goals or with recent treatment changes, frequent or severe hypoglycemia or hyperglycemia, or changes in health status, or during periods of rapid growth and development in children and adolescents. **E**

Table 8: Equivalent A1C levels and estimated average glucose (eAG)

A1C (%)	A1C (mmol/mol)	eAG mg/dL*	eAG mmol/L*
5	31	97 (76–120)	5.4 (4.2–6.7)
6	42	126 (100–152)	7.0 (5.5–8.5)
7	53	154 (123–185)	8.6 (6.8–10.3)
8	64	183 (147–217)	10.2 (8.1–12.1)
9	75	212 (170–249)	11.8 (9.4–13.9)
10	86	240 (193–282)	13.4 (10.7–15.7)
11	97	269 (217–314)	14.9 (12.0–17.5)
12	108	298 (240–347)	16.5 (13.3–19.3)

Data in parentheses are 95% CI. A calculator for converting A1C results into eAG, in either mg/dL or mmol/L, is available at professional.diabetes.org/eAG. *These estimates are based on ADAG data of 82,700 glucose measurements over 3 months per A1C measurement in 507 adults with type 1, type 2, or no diabetes. The correlation between A1C and average glucose was 0.92.

Table 9: CGM metrics for clinical care in nonpregnant individuals with type 1 or type 2 diabetes

Metric	Interpretation	Goals
Metrics for valid CGM wear		
Wear time	Number of days CGM device is worn	≥14-day wear for pattern management
Active percentage time	Percent of time CGM device is active	70% of time active out of 14 days
Glycemic metrics		
Mean glucose	Mean of glucose values	*
Glucose management indicator (GMI)	Calculated value approximating A1C (not always equivalent)	*
Glucose coefficient of variation (CV)	Spread of glucose values	≤36%†
TAR >250 mg/dL (>13.9 mmol/L)	Percent of time in level 2 hyperglycemia	<5% (most adults); <10% (older adults with complex/intermediate health)
TAR >180 mg/dL (>10 mmol/L)	Percent of time in level 1 hyperglycemia	<25% (most adults); <50% (older adults with complex/intermediate health)‡
TIR 70–180 mg/dL (3.9–10.0 mmol/L)	Percent of time in range	>70% (most adults); >50% (older adults with complex/intermediate health)
TBR <70 mg/dL (<3.9 mmol/L)	Percent of time in level 1 hypoglycemia	<4% (most adults); <1% (older adults with complex/intermediate health)§
TBR <54 mg/dL (<3.0 mmol/L)	Percent of time in level 2 hypoglycemia	<1%

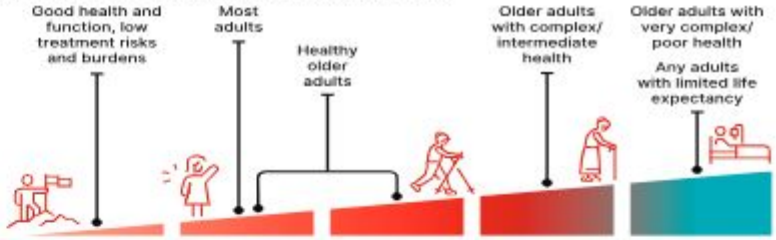
CGM, continuous glucose monitoring; TAR, time above range; TBR, time below range; TIR, time in range. *Goals for these values are not standardized. †Some studies suggest that lower coefficient of variation targets (<33%) provide additional protection against hypoglycemia for those receiving insulin or sulfonylureas. ‡Goals are for level 1 and level 2 hyperglycemia combined. §Goals are for level 1 and level 2 hypoglycemia combined.

GLYCEMIC GOALS

Recommendations

- An A1C goal of <7% (<53 mmol/mol) is appropriate for many nonpregnant adults without severe hypoglycemia or hypoglycemia affecting health or quality of life. **A**
- A goal time in range of >70% in people using CGM is appropriate for many nonpregnant adults. **B**
- A goal percent time <70 mg/dL (<3.9 mmol/L) of <4% (or <1% for older adults) and a goal percent time <54 mg/dL (<3.0 mmol/L) of <1% are recommended in people using CGM to prevent hypoglycemia. Deintensify or modify therapy if these goals are not met. **B**
- Lower A1C goals (e.g., <6.5% [<48 mmol/mol]) may be appropriate for individuals with diabetes with good health and function and low treatment risks (e.g., hypoglycemia) and burdens. **B**
- Less stringent glycemic goals may be appropriate for individuals with significant cognitive and/or functional limitations, frailty, or severe comorbidities or where the harms of treatment, including hypoglycemia, are greater than the benefits. **B**
- Deintensify hypoglycemia-causing medications (insulin, sulfonylureas, or meglitinides), or switch to a medication class with lower hypoglycemia risk, for individuals who are at high risk for hypoglycemia, within individualized glycemic goals. **B**
- Deintensify diabetes medications for individuals for whom the harms and/or burdens of treatment may be greater than the benefits, within individualized glycemic goals. **B**
- Reassess glycemic goals based on the individualized criteria. **E**
- Set a glycemic goal during consultations to improve outcomes. **A**

Figure 6: Individualized A1C and CGM goals for nonpregnant adults.



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

Modifying Factors

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

Select the glycemic goal based on individual health and function as described at the top of the figure. Consider modifying to a more or less stringent goal according to the factors listed in the table. Older adults are classified as healthy (few coexisting chronic illnesses, intact cognitive and functional status), as having complex/intermediate health (multiple coexisting chronic illnesses, two or more instrumental impairments to activities of daily living, or mild to moderate cognitive impairment), or as having very complex/poor health (long-term care or end-stage chronic illnesses, moderate to severe cognitive impairment, or two or more impairments to activities of daily living). Select glycemic goals that avoid symptomatic hypoglycemia and hyperglycemia in all individuals. Consider individuals' resources and support systems to safely achieve glycemic goals. Incorporate the preferences and goals of people with diabetes through shared decision-making. CGM, continuous glucose monitoring; TAR, time above range; TBR, time below range; TIR, time in range..

Table 10: Summary of glycemic goals 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)

*More or less stringent glycemic goals may be appropriate for certain individuals. †CGM may be used to assess glycemic status. Goals should be individualized based on duration of diabetes, age and life expectancy, comorbid conditions, known cardiovascular disease or advanced microvascular complications, impaired awareness of hypoglycemia, and individual considerations. ‡Postprandial glucose may warrant special attention if A1C goals are not met despite reaching preprandial glucose goals. Postprandial glucose measurements should be made 1–2 h after the beginning of the meal, which is generally the timing for peak levels in people with diabetes.

HYPOGLYCEMIA ASSESSMENT, PREVENTION, AND TREATMENT

Recommendations

- Review history of hypoglycemia at every clinical encounter for all individuals at risk for hypoglycemia, and evaluate hypoglycemic events as indicated. **C**
- Screen individuals at risk for hypoglycemia for impaired hypoglycemia awareness at least annually and when clinically appropriate. **E** Refer to a trained health care professional for evidence-based intervention to improve hypoglycemia awareness. **A**
- Screen individuals at high risk for hypoglycemia or with severe and/or frequent hypoglycemia for fear of hypoglycemia at least annually and when clinically appropriate. E Refer to a trained health care professional for evidence-based intervention. **A**
- Consider an individual's risk for hypoglycemia when selecting diabetes medications and glycemic goals. **B**
- Use of CGM is beneficial and recommended for individuals at high risk for hypoglycemia. **A**
- Glucose is the preferred treatment for the conscious individual with glucose <70 mg/dL (<3.9 mmol/L), although any form of carbohydrate that contains glucose may be used. Avoid using foods or beverages high in fat and/or protein for initial treatment of hypoglycemia. Fifteen minutes after initial treatment, repeat the treatment if hypoglycemia persists. **B**
- 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**
- First aid kits should include oral glucose for use in treating hypoglycemia. **C**
- All individuals taking insulin A or at risk for hypoglycemia C should receive structured education for hypoglycemia prevention and treatment, with ongoing education for those who experience hypoglycemic events.
- One or more episodes of level 2 or 3 hypoglycemia should prompt reevaluation of the treatment plan, including deintensifying or switching diabetes medications if appropriate. **B**
- Regularly assess cognitive function; if impaired or declining cognition is found, the clinician, person with diabetes, and caregiver should increase vigilance for hypoglycemia. **B**

Table 11: Classification of hypoglycemia

	Glycemic criteria/description
Level 1	Glucose <70 mg/dL (<3.9 mmol/L) and ≥54 mg/dL (≥3.0 mmol/L)
Level 2	Glucose <54 mg/dL (<3.0 mmol/L)
Level 3	A severe event characterized by altered mental and/or physical status requiring assistance for treatment of hypoglycemia, irrespective of glucose level

6. DIABETES TECHNOLOGY: STANDARDS OF CARE IN DIABETES–2026

GENERAL DEVICE PRINCIPLES

Recommendations

- Diabetes devices should be offered to people with diabetes. **A**
- The type(s) and selection of devices should be individualized based on a person's specific needs, circumstances, preferences, and skill level. In the setting of an individual whose diabetes is partially or wholly managed by someone else (e.g., a young child or a person with cognitive impairment or dexterity, psychosocial issues, and/or physical limitations), the caregiver's skills and preferences are integral to the decision-making process. **E**
- When prescribing a continuous glucose monitoring (CGM) device, ensure that people with diabetes and caregivers are offered initial and ongoing training and education as indicated by individual circumstances. Education should include utilization of data, including uploading or sharing data to monitor and adjust therapy. **C**
- When prescribing an automated insulin delivery (AID) system, people with diabetes and their caregivers must receive education on how to use and troubleshoot the system. This education should occur at regular intervals as needed. Education should include utilization of the integrated system and its data, including uploading or sharing data to monitor and adjust therapy. **C**
- Health care professionals working with people with diabetes should be aware of available technologies and seek additional support when needed. **E**
- People with diabetes using CGM, continuous subcutaneous insulin infusion (CSII), and/or AID for diabetes management should have continued access to devices across third-party payors, regardless of age or A1C levels. **E**
- Children and adolescents should be supported at school in the use of diabetes technology, such as CGM systems, CSII, connected insulin pens, and AID systems. **E**
- For adults with diabetes using diabetes technology, reasonable accommodations in educational and work settings should include having sufficient time to manage their devices and respond to high and low glucose levels. **E**
- Consider early initiation, including at diagnosis, of CGM, CSII, and AID depending on a person's or caregiver's needs and preferences. **C**
- There should be no requirement of C-peptide level, **B** the presence of islet autoantibodies, **B** or duration of insulin treatment C before initiation of CSII or AID.
- Standardized reports for all CGM, CSII, AID, and connected insulin devices with a minimum of a single-page report, such as the standardized CGM report and weekly summary, should be available and utilized. Options for daily and weekly reports and raw data should be available. **E**

BLOOD GLUCOSE MONITORING

Recommendations

- People with diabetes should be provided with blood glucose monitoring (BGM) devices as indicated by their circumstances, preferences, and treatment. People using CGM devices must also have access to BGM at all times. **A**
- People who are taking insulin and using BGM should be encouraged to check their blood glucose levels when appropriate based on their insulin therapy. This may include checking when fasting, prior to meals and snacks, after meals, at bedtime, in the middle of the night, prior to, during, and after exercise, when hypoglycemia is suspected, after treating low blood glucose levels until

achieving normoglycemia, when hyperglycemia is suspected, and prior to and while performing critical tasks such as driving. **B**

- Health care professionals should be aware of the differences in accuracy among blood glucose meters. Only meters approved by the U.S. Food and Drug Administration (FDA) (or comparable regulatory agencies for other geographical locations) with proven accuracy should be used, with unexpired test strips purchased from a pharmacy or licensed distributor and properly stored. **E**
- Although BGM in people on noninsulin therapies has not consistently shown clinically significant reductions in A1C levels, it may be helpful when modifying meal plans, physical activity plans, and/or medications (particularly medications that can cause hypoglycemia) in conjunction with a treatment adjustment program. **E**
- Consider potential interference of medications and substances on glucose levels measured by blood glucose meters. **B**

Table 12: Comparison of ISO 15197:2013 and FDA blood glucose meter accuracy standards

Setting	FDA*	ISO 15197:2013*
Hospital use	95% within 12% for BG ≥75 mg/dL 95% within 12 mg/dL for BG <75 mg/dL 98% within 15% for BG ≥75 mg/dL 98% within 15 mg/dL for BG <75 mg/dL	95% within 15% for BG ≥100 mg/dL 95% within 15 mg/dL for BG <100 mg/dL 99% in A or B region of consensus error grid‡
Home use	95% within 15% for all BG in the usable BG range† 99% within 20% for all BG in the usable BG range†	

BG, blood glucose; FDA, U.S. Food and Drug Administration; ISO, International Organization for Standardization. To convert mg/dL to mmol/L, see endmemo.com/medical/unitconvert/Glucose.php. *Data shown in the FDA column are from the FDA (191). Data shown in the ISO column are from the FDA. †The range of blood glucose values for which the meter has been proven accurate and will provide readings (other than low, high, or error). ‡Values outside of the "clinically acceptable" A and B regions are considered "outlier" readings and may be dangerous to use for therapeutic decisions.

CONTINUOUS GLUCOSE MONITORING DEVICES

Recommendations

- Use of CGM is recommended at diabetes onset and anytime thereafter for children, adolescents, and adults with diabetes who are on insulin therapy, **A** on noninsulin therapies that can cause hypoglycemia, **C** and on any diabetes treatment where CGM helps in management. **C** The specific CGM device and method for use should be made based on the individual's circumstances, preferences, and needs. **E**
- In people with diabetes on insulin therapy, CGM devices should be used as close to daily as possible for maximal benefit. **A** People with diabetes should have uninterrupted access to their supplies to minimize gaps in CGM. **A**
- During pregnancy for individuals with type 1 diabetes, CGM can help achieve glycemic goals (e.g., time in range and time above range) **A** and A1C goal **B** and may be beneficial for other types of diabetes in pregnancy. **E** See section "Management of Diabetes in Pregnancy," for more detail regarding use of technology in pregnancy.
- In circumstances when consistent use of CGM is not feasible, consider periodic use of personal or professional CGM to adjust medication and/or lifestyle. **C**
- Skin reactions, either due to irritation or allergy, should be assessed and addressed to aid in successful use of devices. **E**
- People who wear CGM devices should be educated on potential interfering substances and other factors that may affect accuracy. **C**

Table 13: Some of the more common interfering substances and/or conditions that affect blood glucose meters (for inpatient and outpatient use)

Substance or condition	Potential effects on glucose readings measured by BGMs*
Maltose†	Falsely higher blood glucose readings
Galactose	Falsely higher blood glucose readings
Xylose	Falsely higher blood glucose readings
N-Acetylcysteine	Falsely higher or lower blood glucose readings (depending on BGM design)
Acetaminophen	Falsely higher or lower blood glucose readings (depending on BGM design)
Dopamine	Falsely higher or lower blood glucose readings (depending on BGM design)
Pralidoxime (2-PAM)	Falsely higher or lower blood glucose readings (depending on BGM design)
Hydroxyurea	Falsely higher or lower blood glucose readings (depending on BGM design)
Vitamin C	Falsely higher or lower blood glucose readings (depending on BGM design)
Hematocrit (high)	Falsely lower blood glucose readings
Hematocrit (low)	Falsely higher blood glucose readings

*These are potential effects. There are blood glucose monitors (BGMs) that behave differently than listed in this table. Refer to product labeling for product-specific information. †Unmodified glucose dehydrogenase pyrroloquinoline quinone (GDH/PQQ) enzyme method only. Modern BGM designs do not incorporate unmodified GDH-PQQ enzyme.

Table 14: Continuous glucose monitoring devices

Type of device	Brand*	Availability	Alarms
rtCGM	Libre 2 Plus and Libre 3 Plus	Prescription	Yes
	Dexcom G6 and G7	Prescription	Yes
	Eversense 365	Prescription	Yes
	Guardian 4	Prescription	Yes
	Simplera	Prescription	Yes
OTC-CGM	Dexcom Stelo	OTC	No
	Abbott Lingo	OTC	No
Professional CGM	Abbott FreeStyle Libre Pro	In office	No
	Dexcom G6 Pro	In office	No

CGM, continuous glucose monitoring; isCGM, intermittently scanned CGM; OTC, over the counter; rtCGM, real-time CGM. *Generic names not available.

Table 15: Continuous glucose monitoring device interfering substances

Medication	Systems affected	Effect
Acetaminophen		
>4 g/day	Dexcom G6, Dexcom G7	Higher sensor readings than actual glucose
Any dose	Medtronic Guardian 4	Higher sensor readings than actual glucose
Ascorbic acid (vitamin C), >500 mg/day	FreeStyle Libre 2, FreeStyle Libre 3	Higher sensor readings than actual glucose
Ascorbic acid (vitamin C), >1,000 mg/day	FreeStyle Libre 2 Plus, FreeStyle Libre 3 Plus	Higher sensor readings than actual glucose
Hydroxyurea	Dexcom G6, Dexcom G7, Medtronic Guardian 4	Higher sensor readings than actual glucose
Mannitol (intravenously or as peritoneal dialysis solution)	Senseonics Eversense365	Higher sensor readings than actual glucose
Sorbitol (intravenously or as peritoneal dialysis solution)	Senseonics Eversense365	Higher sensor readings than actual glucose

INSULIN DELIVERY

Insulin Syringes and Pens

Recommendations

- For people with insulin-requiring diabetes on multiple daily injections (MDI), insulin pens are preferred in most cases. Still, insulin syringes may be used for insulin delivery considering individual and caregiver preference, insulin type, availability in vials, dosing therapy, cost, and selfmanagement capabilities. **C**
- Insulin pens or insulin injection aids are recommended for people with dexterity issues or vision impairment or when decided by shared decision making to facilitate the accurate dosing and administration of insulin. **C**
- Offer connected insulin pens for people with diabetes taking multiple daily insulin injections when appropriate. **B**
- FDA-approved insulin dose calculators/decision support systems may be helpful for calculating insulin doses. **B**

Insulin Pumps and Automated Insulin Delivery Systems

Recommendations

- AID systems are the preferred insulin delivery method over MDI, CSII, and sensor-augmented pumps in people with type 1 diabetes, **A** adults with type 2 diabetes, **A** children and adolescents with type 2 diabetes, E and those with other forms of insulindeficient diabetes. **B, C, D, E** Choice of an AID system should be made based on the individual's circumstances, preferences, and needs. **E**
- Consider AID systems for select people with type 2 diabetes treated with basal insulin not achieving individualized glycemic goals. **B** Choice of an AID system should be made basedon the individual's circumstances, preferences, and needs. **E**
- Individuals with diabetes who have been using CSII and/or AID should have continued access across thirdparty payors. **E**

Open-Source Automated Insulin Dosing

Recommendations

- Support and provide diabetes management advice to people with diabetes who choose to use an opensource AID system. **B**

Digital Health Technology

Recommendations

- IConsider combining technology (CGM, insulin pump, and/or diabetes apps) with online or virtual licensed coaching to improve glycemic outcomes in individuals with diabetes or prediabetes. **B**

Inpatient Care

Recommendations

- In people with diabetes wearing personal CGM, the use of CGM should be continued when clinically appropriate during hospitalization, with confirmatory point-of-care glucose measurements for insulin dosing and hypoglycemia assessment and treatment under an institutional protocol. **B**
- Continue use of insulin pump or AID in people with diabetes who are hospitalized when clinically appropriate. This is contingent upon availability of necessary supplies, resources, training, ongoing competency assessments, and implementation of institutional diabetes technology protocols. **C**

7. OBESITY AND WEIGHT MANAGEMENT FOR THE PREVENTION AND TREATMENT OF DIABETES: STANDARDS OF CARE IN DIABETES–2026

Diabetes Care 2026;49(Suppl. 1):S166–S182

ASSESSMENT AND MONITORING OF THE INDIVIDUAL WITH OVERWEIGHT AND OBESITY

Recommendations

- Use person-centered, nonjudgmental language that fosters collaboration between individuals and health care professionals, including person-first language (e.g., "person with obesity" rather than "obese person" and "person with diabetes" rather than "diabetic person"). **E**
- Screen for overweight and obesity using BMI annually. To confirm excess adiposity, additional assessments of body fat using anthropometric assessments (e.g., waist-to-hip ratio) or direct measurements (e.g., dual-energy X-ray absorptiometry, bioelectrical impedance analysis) could be considered where available/feasible. **E**
- Monitor obesity-related anthropometric measurements at least annually to inform treatment considerations. During active weight management treatment, increase monitoring to at least every 3 months. **E**
- Accommodations should be made to provide privacy during anthropometric measurements. **E**
- In people with type 2 diabetes and overweight or obesity, weight management should represent a primary goal of treatment along with glycemic management. **A**
- Provide weight management treatment, aiming for any magnitude of weight loss. Weight loss of 5–7% of baseline weight improves glycemia and other intermediate cardiovascular risk factors. **A** Sustained loss of >10% of body weight usually confers greater benefits, including disease-modifying effects and possible remission of type 2 diabetes **A** and may improve long-term cardiovascular outcomes and mortality. **B**
- Individualize initial treatment approaches for obesity (i.e., lifestyle and nutritional therapy, pharmacologic therapy, or metabolic surgery) **A** based on the person's medical history, life circumstances, and preferences. **C** Consider combining treatment approaches if appropriate. **C**

NUTRITION, PHYSICAL ACTIVITY, AND BEHAVIORAL THERAPY INTERVENTIONS

Recommendations

- Nutrition, physical activity, and behavioral therapy are recommended for people with type 2 diabetes and overweight or obesity to achieve both weight and health outcome goals. **B**
- Interventions including high frequency of counseling (≥16 sessions in 6 months) with focus on nutrition changes, physical activity, and behavioral strategies to achieve a 500–750 kcal/day energy deficit (irrespective of macronutrient composition) should be recommended for weight loss when available. **A**
- If access to such interventions is limited, consider alternative structured programs delivering nutrition changes, physical activity, and behavioral counseling (e.g., remote, telehealth, mobile app). **E**
- Nutrition recommendations should be individualized to the person's preferences and nutritional needs. Use nutritional plans that create an energy deficit, while still following general nutritional guidance, to achieve weight loss. **A**
- When developing a plan of care, consider systemic, structural, cultural, and socioeconomic factors that may impact nutrition patterns and food choices, such as food insecurity and hunger, access to healthfulfood options, and other social determinants of health. **C**

- For those who achieve weight loss goals, continue to monitor progress, provide ongoing support, and recommend continuing interventions to maintain weight goals long term. **E** Effective long-term (≥1 year) weight maintenance programs provide monthly contact and support, include frequent self-monitoring of body weight (weekly or more frequently) and other selfmonitoring strategies (e.g., food diaries or wearables), and encourage regular physical activity (200–300 min/week). **A**
- Short-term nutrition intervention using structured, very-low-calorie meals (800–1,000 kcal/day) should be prescribed only to carefully selected individuals by trained practitioners in medical settings with close monitoring. Long-term, comprehensive weight maintenance strategies and counseling should be integrated to maintain weight loss. **B**
- Nutritional supplements are not recommended, as they have not been shown to be effective for weight loss. **A**
- Counsel and regularly monitor individuals pursuing intentional weight loss to ensure adequate nutritional intake, with particular attention to preventing protein insufficiency and micronutrient deficiencies. **E**

Table 16: Obesity pharmacotherapy in individuals with type 2 diabetes

Medication name	Treatment arm; weight loss from baseline	Time frame for weight loss (weeks)*	Common side effects	Possible safety concerns and considerations
Sympathomimetic amine anorectic; approved for short-term use only Phentermine (103,104)¶	• 15 mg q.d.; 7.4% • 7.5 mg q.d.; 6.6% • Placebo; 2.3%	28	Dry mouth, insomnia, dizziness, irritability, increased blood pressure, elevated heart rate	• Contraindicated for use in combination with monoamine oxidase inhibitors • Contraindicated with a history of cardiovascular disease • Do not use if at high risk for glaucoma due to risk of acute angle-closure glaucoma
Lipase inhibitor Orlistat (4,105)‖	• 120 mg t.i.d.; 8.6% • Placebo; 5.6%	52	Abdominal pain, flatulence, fecal urgency	• Contraindicated in cholestasis • Potential malabsorption of fat-soluble vitamins (A, D, E, K) and of certain medications (e.g., cyclosporine, thyroid hormone, anticonvulsants) • Rare cases of severe liver injury reported • Cholelithiasis reported • Nephrolithiasis reported. Monitor renal function and discontinue if oxalate nephropathy occurs
Sympathomimetic amine anorectic/ antiepileptic combination Phentermine/topiramate ER (54,116)¶	• 15 mg/92 mg q.d.; 9.8% • 7.5 mg/46 mg q.d.; 7.8% • Placebo; 1.2%	56	Constipation, paresthesia, insomnia, nasopharyngitis, xerostomia, increased blood pressure, nephrolithiasis	• Contraindicated for use in combination with monoamine oxidase inhibitors • Contraindicated during pregnancy due to risk of fetal harm with topiramate • Cognitive impairment associated with rapid dose titration or high initial doses • Caution with cardiovascular disease • Do not use if at high risk for glaucoma due to risk of acute angle-closure glaucoma
Opioid antagonist/antidepressant combination Naltrexone/bupropion ER (13,106)	• 16 mg/180 mg b.i.d.; 6%** • Placebo; 1.8%	56	Constipation, nausea, headache, xerostomia, insomnia, elevated heart rate and blood pressure	• Contraindicated in people with uncontrolled hypertension and/or seizure disorders • Contraindicated for use with chronic opioid therapy • Acute angle-closure glaucoma may occur • Increased blood pressure and heart rate may occur; monitor in people with cardiovascular and cerebrovascular disease • Risk of suicidal behavior/ideation in people younger than 24 years old who have depression
GLP-1 receptor agonist Liraglutide (54,55,107)	• 3.0 mg q.d.; 8% • 1.8 mg q.d.; 4.7% • Placebo; 2%	56	Gastrointestinal side effects (nausea, vomiting, diarrhea, esophageal reflux, constipation)	The following apply to both GLP-1 receptor agonists: • Provide guidance on discontinuation prior to surgical procedures to mitigate potential for pulmonary aspiration with general anesthesia or deep sedation

Medication name	Treatment arm; weight loss from baseline	Time frame for weight loss (weeks)*	Common side effects	Possible safety concerns and considerations
Semaglutide (56,117,118)	• 2.4 mg weekly; 9.6% • 1.0 mg weekly; 7% • Placebo; 2.4%			• Pancreatitis: acute pancreatitis has been reported, but causality has not been established. Do not initiate if at high risk for pancreatitis and discontinue if pancreatitis is suspected • Biliary disease: evaluate for gallbladder disease if cholelithiasis or cholecystitis is suspected; avoid use in at-risk individuals • Gastrointestinal disorders (severe constipation and small bowel obstruction/ileus progression) • Diabetic retinopathy: close monitoring of retinopathy in those at high risk (older individuals and those with longer duration of type 2 diabetes [≥10 years]) • Nonarteritic anterior ischemic optic neuropathy reported; rare incidence. Monitor for this during eye examinations • Impact on drug absorption: orally administered drug absorption may be impaired during dose titration (including oral contraceptives)

				• Gastrointestinal side effects: counsel on potential for gastrointestinal side effects; provide guidance on dietary modifications to mitigate gastrointestinal side effects (reduction in meal size, mindful eating practices [e.g., stop eating once full], decreasing intake of high-fat or spicy foods); consider slower dose titration for those experiencing gastrointestinal challenges. Not recommended for individuals with gastroparesis • Hypoglycemia (with concomitant use of insulin or sulfonylurea) • Risk of thyroid C-cell tumors in rodents; human relevance not determined; do not use in individuals with personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type 2
Dual GIP and GLP-1 receptor agonist Tirzepatide (10/5/28%)	• 15 mg weekly: 14.7% • 10 mg weekly: 12.8% • Placebo: 3.2%	72	Gastrointestinal side effects (nausea, vomiting, diarrhea, esophageal reflux, constipation)	Same as for GLP-1 receptor agonists, with addition of the following: • Monitor effects of oral medications with narrow therapeutic index (warfarin) or whose efficacy is dependent on threshold concentration • Advise individuals using oral contraceptives to switch to a nonoral contraceptive method or add a barrier method of contraception for 4 weeks after initiation and for 4 weeks after each dose escalation

Select safety and side effect information is provided; for a comprehensive discussion of safety considerations, please refer to the prescribing information for each agent. b.i.d., twice daily; ER, extended release; GIP, glucose-dependent insulinotropic polypeptide; GLP-1, glucagon-like peptide 1; q.d., every day; Rx, prescription; t.i.d., three times daily, p.o., by mouth. *Time frames used in clinical trials. Medications approved for long-term use should be continued as indicated beyond reaching weight loss goals. Phentermine was evaluated in a general adult population with obesity. As monotherapy. † phentermine is only approved for short-term use. Use lowest effective dose; maximum appropriate dose is 37.5 mg. ‡Enrolled participants had normal (79%) or impaired (21%) glucose tolerance. ǁ - Maximum dose, depending on response, is 15 mg/92 mg q.d. Approximately 68% of enrolled participants had type 2 diabetes or impaired glucose tolerance. Agent has indication for reduction of car §diovascular events.

PHARMACOTHERAPY

Recommendations

- Whenever clinically appropriate, engage other care team members to minimize use of weight-promoting medications for treatment of other conditions among adults with diabetes and obesity. **E**
- When choosing glucose-lowering medications for people with type 2 diabetes and overweight or obesity, prioritize medications with beneficial effect on weight. **B**
- Obesity pharmacotherapy should be considered for people with diabetes and overweight or obesity along with lifestyle changes. Potential benefits and risks must be considered. **A**
- In people with diabetes and overweight or obesity, the preferred pharmacotherapy should be a glucagonlike peptide 1 receptor agonist or dual glucose-dependent insulinotropic polypeptide and glucagon-like peptide 1 receptor agonist with greater weight loss efficacy (i.e., semaglutide or tirzepatide), especially considering their added weight-independent benefits. **A**
- Obesity pharmacotherapy indicated for chronic therapy should be continued beyond reaching weight loss goals to maintain the health benefits, as discontinuation often results in recurrence of weight gain and worsening or reemergence of cardiometabolic risk factors. **B**
- Individualize the dose and the dose titration approach of obesity pharmacotherapy to balance effectiveness, health benefits, and tolerability; the optimal treatment dose may not be the maximum approved dose. **B**
- In people with diabetes not reaching weight treatment goals, modify or intensify treatment with additional approaches, including structured lifestyle management programs, metabolic surgery, A and additional or alternative pharmacologic agents. **B**

METABOLIC SURGERY

Recommendations

- Consider metabolic surgery as a weight and glycemic management approach in people with type 2 diabetes with BMI ≥30.0 kg/m^2 (or ≥27.5 kg/m^2 in Asian American individuals) who are otherwise good surgical candidates. **A**
- Metabolic surgery should be performed in high-volume centers with interprofessional teams knowledgeable about and experienced in managing obesity, diabetes, and gastrointestinal surgery. **E**

- People being considered for metabolic surgery should be evaluated for comorbid psychological conditions and social and situational circumstances that have the potential to interfere with surgery outcomes. **B**
- People who undergo metabolic surgery should receive long-term medical and behavioral support and routine micronutrient, nutritional, and metabolic status monitoring. **B**
- If post–metabolic surgery hypoglycemia is suspected, clinical evaluation should exclude other potential disorders contributing to hypoglycemia, and management should include education, medical nutrition therapy with a registered dietitian nutritionist experienced in post–metabolic surgery hypoglycemia, and medication treatment, as needed. **A** In individuals with post–metabolic surgery hypoglycemia, use continuous glucose monitoring to improve safety. **C**
- In people who undergo metabolic surgery, routinely screen for psychosocial and behavioral health changes and refer to a qualified behavioral health professional as needed. **C**
- Monitor individuals who have undergone metabolic surgery for insufficient weight loss or weight recurrence at least every 6–12 months. **E** In those who have insufficient weight loss or experience weight recurrence, assess for potential predisposing factors and, if appropriate, consider additional weight loss interventions (e.g., obesity pharmacotherapy). **C**

8. PHARMACOLOGIC APPROACHES TO GLYCEMIC TREATMENT: STANDARDS OF CARE IN DIABETES–2026

Diabetes Care 2026;49(Suppl. 1):S183–S215

PHARMACOLOGIC THERAPY FOR ADULTS WITH TYPE 1 DIABETES

Recommendations

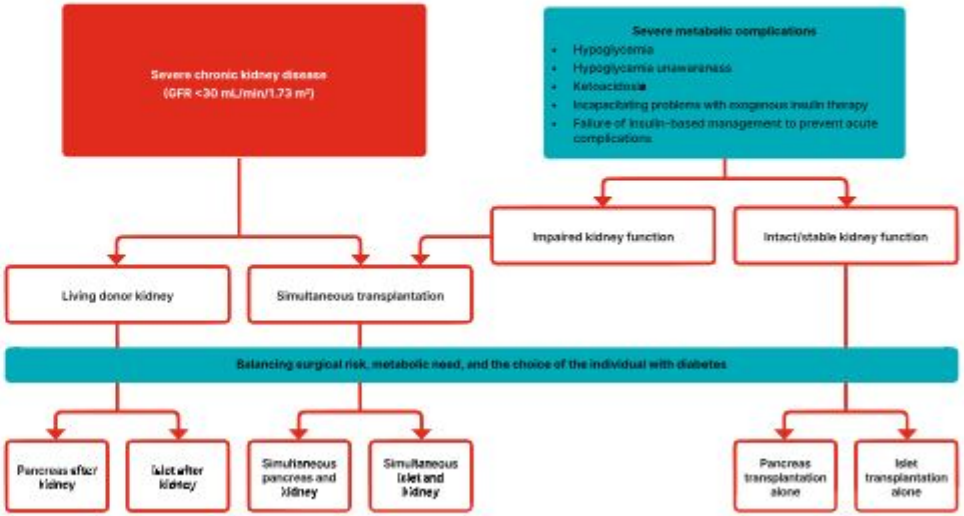
- Treat most adults with type 1 diabetes with continuous subcutaneous insulin infusion or multiple daily doses of prandial (injected or inhaled) and basal insulin. **A**
- For most adults with type 1 diabetes, insulin analogs (or inhaled insulin) are preferred over injectable human insulins to minimize hypoglycemia risk. **A**
- To improve glycemic outcomes and quality of life and to minimize hypoglycemia risk, most adults with type 1 diabetes should receive education on how to match mealtime insulin doses to carbohydrate intake and fat and protein intake depending on the person's or caregiver's needs or preferences. They should also be taught how to modify the insulin dose (correction dose) based on concurrent glycemia, glycemic trends (if available), sick-day management, and anticipated physical activity. **B**
- Insulin treatment plans and insulin-taking behaviors should be reevaluated at regular intervals (e.g., every 3–6 months) and adjusted to incorporate specific factors that affect choice of treatment and ensure achievement of individualized glycemic goals. **E**

Figure 7: Choices of insulin plans in people with type 1 diabetes.

Insulin plans	Greater flexibility	Lower risk of hypoglycemia	Higher costs
MDI with LAA + RAA or URAA	+++	+++	$$$
Less-preferred, alternative injected insulin plans			
MDI with NPH + RAA or URAA	++	++	$$
MDI with NPH + short-acting (regular) insulin	++	+	$
Two daily injections with NPH + short-acting (regular) insulin or premixed	+	+	$
Continuous insulin infusion plans	**Greater flexibility**	**Lower risk of hypoglycemia**	**Higher costs**
Automated insulin delivery systems	+++++	+++++	$$$$$
Insulin pump with threshold/ predictive low-glucose suspend	++++	++++	$$$$$
Insulin pump therapy without automation	+++	+++	$$$$

Continuous glucose monitoring improves outcomes with injected or infused insulin and is superior to blood glucose monitoring. Inhaled insulin may be used in place of injectable prandial insulin in the U.S. The number of plus or dollar signs is an estimate of relative association of the plan with greater flexibility, lower risk of hypoglycemia, and higher costs between the different plans. Cost symbols are reflective of general costs, which may vary for individuals based on various circumstances: insurance coverage, discounts, rebates, and other price adjustments involved in prescription sales. LAA, long-acting insulin analog; MDI, multiple daily injections; RAA, rapid-acting insulin analog; URAA, injectable ultra-rapid-acting insulin analog or inhaled insulin.

Figure 8: Simplified overview of indications for β-cell replacement therapy in people with type 1 diabetes.



The two main forms of β-cell replacement therapy are whole pancreas transplantation and islet cell transplantation. β-Cell replacement therapy can be combined with kidney transplantation if the individual has kidney failure, which may be performed simultaneously or after kidney transplantation. All decisions about transplantation must consider the surgical risk, metabolic need, and the choices of the individual with diabetes. GFR, glomerular filtration rate.

PHARMACOLOGIC THERAPY FOR ADULTS WITH TYPE 2 DIABETES

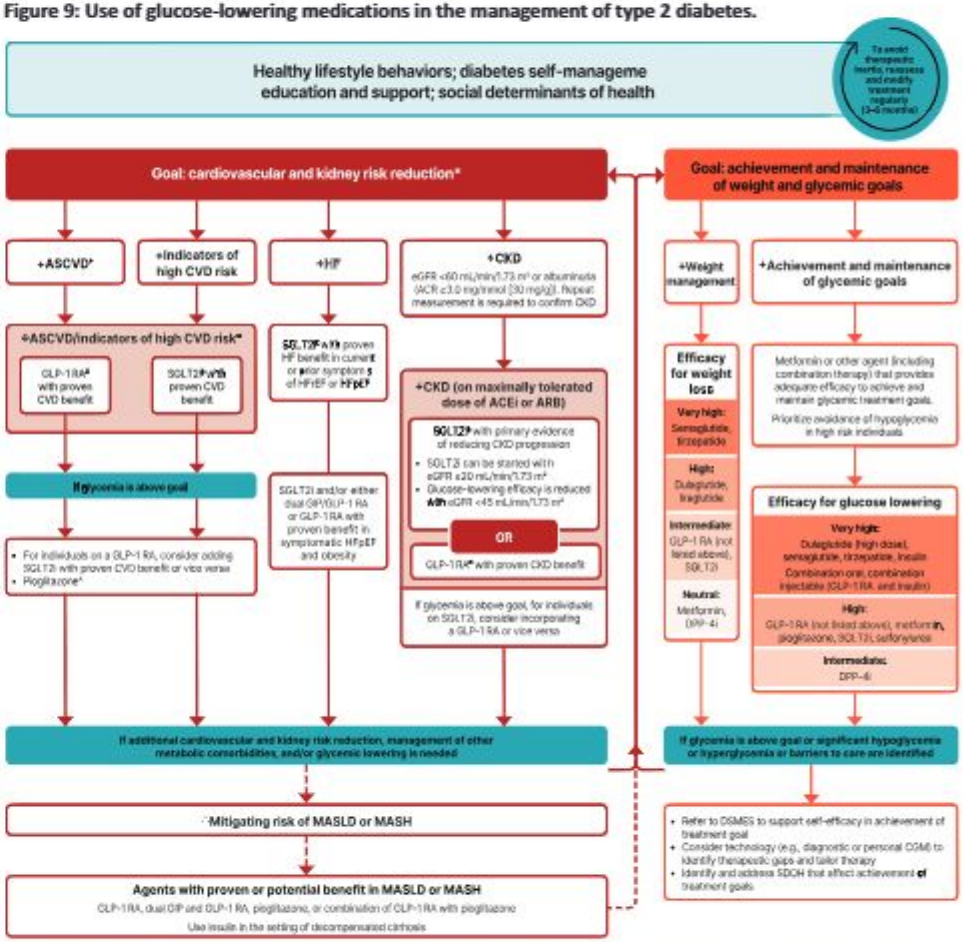
Recommendations

- A person-centered shared decisionmaking approach should guide the choice of glucose-lowering medications for adults with type 2 diabetes. Use medications that provide sufficient effectiveness to achieve and maintain intended treatment goals with consideration of the effects on cardiovascular, kidney, weight, and other relevant comorbidities; hypoglycemia risk; cost and access; risk for adverse reactions and tolerability; and individual preferences. **E**
- Consider combination therapy in adults with type 2 diabetes for initial treatment to shorten time to attainment of individualized glycemic goals. **A**
- In adults with type 2 diabetes and established or high risk of atherosclerotic cardiovascular disease, the treatment plan should include medications with demonstrated benefits to reduce cardiovascular events (e.g., glucagonlike peptide 1 receptor agonist [GLP-1 RA] and/or sodium–glucose cotransporter 2 [SGLT2] inhibitor) for glycemic management and comprehensive cardiovascular risk reduction (irrespective of A1C). **A**
- In adults with type 2 diabetes who have heart failure (HF) (with either reduced or preserved ejection fraction), an SGLT2 inhibitor is recommended for both glycemic management and prevention of HF hospitalizations (irrespective of A1C). **A**
- In adults with type 2 diabetes, obesity, and symptomatic heart failure with preserved ejection fraction (HFpEF), the glucose-lowering treatment plan should include a dual glucosedependent insulinotropic polypeptide (GIP) and GLP-1 RA with demonstrated benefits for HF-related symptoms and reduction in HF events (irrespective of A1C). **A**

- In adults with type 2 diabetes, obesity, and symptomatic HFpEF, the glucose-lowering treatment plan should include a GLP-1 RA with demonstrated benefits for HF-related symptoms A and/or reduction in HF events (irrespective of A1C). **B**
- In adults with type 2 diabetes who have chronic kidney disease (CKD) (with confirmed estimated glomerular filtration rate [eGFR] 20–60 mL/min/1.73 m^2 and/or albuminuria), an SGLT2 inhibitor or GLP-1 RA with demonstrated benefit in this population should be used for both glycemic management and for slowing progression of CKD and reduction in cardiovascular events (irrespective of A1C). The glycemic benefits of SGLT2 inhibitors are reduced at eGFR <45 mL/min/1.73 m^2. **A**
- In adults with type 2 diabetes and advanced CKD (eGFR <30 mL/min/1.73 m^2), a GLP-1 RA is preferred for glycemic management due to lower risk of hypoglycemia and for cardiovascular event reduction. **B** Individuals on dialysis can be safely initiated or continued on GLP-1–based therapy (that is not dependent on kidney clearance) to reduce cardiovascular risk and mortality. **C**
- In adults with type 2 diabetes, metabolic dysfunction–associated steatotic liver disease (MASLD), and overweight or obesity, consider using a GLP-1 RA with demonstrated benefits in metabolic dysfunction–associated steatohepatitis (MASH) **A** or a dual GIP and GLP-1 RA with potential benefits in MASH **B** for glycemic management and as an adjunctive therapy to interventions for weight loss.
- In adults with type 2 diabetes and biopsy-proven MASH or those at high risk for liver fibrosis (based on noninvasive tests), a GLP-1 RA is preferred for glycemic management due to beneficial effects on MASH. A Pioglitazone or a dual GIP and GLP-1 RA **B** can be considered for glycemic management due to potential beneficial effects on MASH. **B**
- Combination therapy with pioglitazone plus a GLP-1 RA can be considered for the treatment of hyperglycemia in adults with type 2 diabetes with biopsy-proven MASH or those at high risk of liver fibrosis (identified with noninvasive tests) due to potential beneficial effects on MASH. **B**
- Medication plan and medicationtaking behavior should be reevaluated at regular intervals (e.g., every 3–6 months) and adjusted as needed to incorporate specific factors that affect choice of treatment and ensure achievement of individualized glycemic goals. **E**
- Treatment modification (including intensification or deintensification) for adults not meeting individualized treatment goals should not be delayed. **A**
- Choice of glucose-lowering therapy modification should take into consideration individualized glycemic and weight goals, presence of comorbidities (cardiovascular, kidney, liver, and other metabolic comorbidities), and the risk of hypoglycemia. **A**
- When initiating a new glucoselowering medication, reassess the need for and/or dose of medications with higher hypoglycemia risk (i.e., sulfonylureas, meglitinides, and insulin) to minimize the risk of hypoglycemia and treatment burden. **A**
- Concurrent use of dipeptidyl peptidase 4 (DPP-4) inhibitors with a GLP-1 RA or a dual GIP and GLP-1 RA is not recommended due to lack of additional glucose lowering beyond that of a GLP-1–based therapy. **B**
- In adults with type 2 diabetes who have not achieved their individualized weight goals, additional weight management interventions (e.g., intensification of lifestyle modifications, structured weight management programs, pharmacologic agents, or metabolic surgery, as appropriate) are recommended. **A**
- In adults with type 2 diabetes, initiation of insulin should be considered regardless of background glucoselowering therapy or disease duration if symptoms of hyperglycemia are present or when A1C or blood glucose levels are very high (i.e., A1C >10% [>86 mmol/mol] or blood glucose ≥300 mg/dL [≥16.7 mmol/L]). **E**

- In adults with type 2 diabetes without severe hyperglycemia or hyperglycemic crisis, GLP-1–based therapy is preferred to insulin for initial or add-on glucose-lowering therapy. **A**
- If insulin is used, combination therapy with a GLP-1 RA, including a dual GIP and GLP-1 RA, is recommended for greater glycemic effectiveness as well as beneficial effects on weight and hypoglycemia risk for adults with type 2 diabetes. Insulin dosing should be reassessed upon addition or dose escalation of a GLP-1 RA or dual GIP and GLP-1 RA. **A**
- In adults with type 2 diabetes who are initiating insulin therapy, continue glucose-lowering agents (unless contraindicated or not tolerated) for ongoing glycemic and metabolic benefits (i.e., weight, cardiometabolic, or kidney benefits). **A**

Figure 9: Use of glucose-lowering medications in the management of type 2 diabetes.



* 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 (eg, 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, HHF, 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.

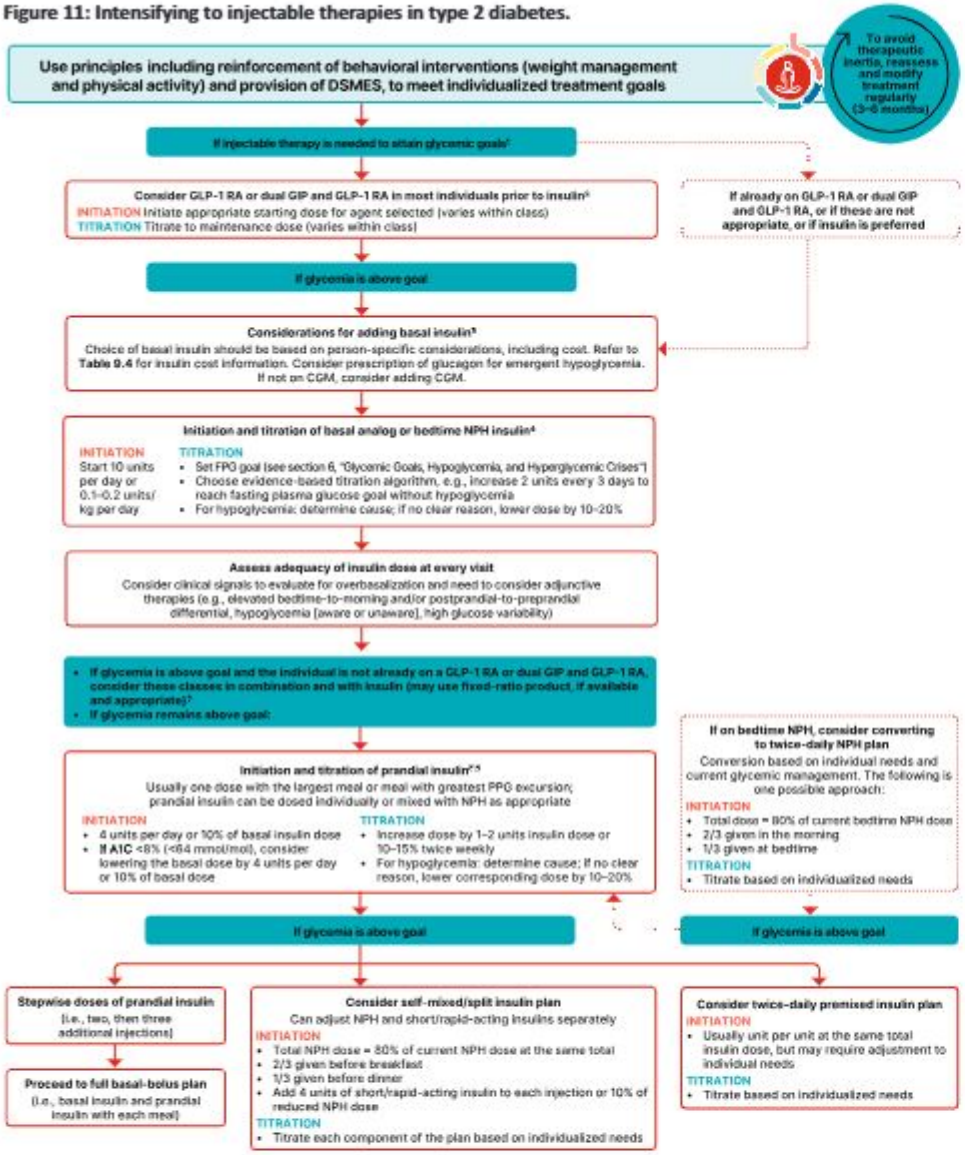
The left side of the algorithm prioritizes mitigation of diabetes-related complications and end-organ effects, while the right side addresses weight and glucose management goals. ACEi, angiotensinconverting enzyme inhibitor; ACR, albumin-to-creatinine ratio; ARB, angiotensin receptor blocker; ASCVD, 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; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; 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.

Table 17: Features of medications for lowering glucose in type 2 diabetes

Medication (route of administration)	Glucose-lowering efficacy^3^	Hypoglycemia risk	Weight effects*	CV effects: Effect on MACE	CV effects: Effect on HF	Kidney effects: Progression of CKD	Kidney effects: Dosing/use considerations*	MASH effects	Clinical considerations and adverse effects
Metformin (oral)	High	No	Neutral (potential for modest loss)	Potential benefit	Neutral	Neutral	• Contraindicated with eGFR <30 mL/min/1.73 m²	Neutral	• GI side effects: mitigate with slow dose titration, extended-release formulations, and administration with food • Potential for vitamin B12 deficiency: monitor and replete as appropriate
SGLT2 inhibitors (oral)	Intermediate to high	No	Loss (intermediate)	Benefit: canagliflozin, empagliflozin	Benefit: canagliflozin, dapagliflozin, empagliflozin, ertugliflozin	Benefit: canagliflozin, empagliflozin, dapagliflozin	• See labels of individual agents for dosage considerations for kidney function • Glucose-lowering effect is minimal at eGFR <45 mL/min/1.73 m² and lower; continue or start for cardiovascular and kidney benefit if eGFR ≥20 mL/min/1.73 m²; May continue until dialysis or transplantation	Unknown	• DKA risk in individuals with insulin deficiency (rare in T2D): discontinue, evaluate, and treat promptly if suspected; be aware of predisposing risk factors and clinical presentations (including euglycemic DKA); mitigate risk with sick-day planning; discontinue before scheduled surgery (e.g., 3–4 days), during critical illness, or during prolonged fasting • Genital mycotic infections: mitigate risk with genital hygiene and avoid use in high-risk individuals • Urosepsis and pyelonephritis: evaluate individuals for signs and symptoms of urinary tract infections and treat promptly • Necrotizing fasciitis in the perineum (Fournier gangrene): rare; prompt treatment if suspected • Intravascular volume depletion: attention to volume status and blood pressure, particularly when ill or fasting; adjust other volume-contracting agents as applicable; monitor kidney function upon initiation
GLP-1 RAs (SQ; semaglutide also available in oral formulation)	High to very high	No	Loss (intermediate to very high)	Benefit: dulaglutide, liraglutide, semaglutide (SQ and oral) Neutral: exenatide once weekly, lixisenatide	Benefit: semaglutide (SQ)	Benefit for kidney end points in CVOTs, driven by albuminuria outcomes: dulaglutide, liraglutide, semaglutide (SQ) Demonstrated benefit for progression of CKD for semaglutide (SQ)	• See labels of individual agents for dosage considerations for kidney function • No dose adjustment for dulaglutide, liraglutide, or semaglutide • Monitor kidney function when initiating or escalating doses in individuals with kidney impairment reporting severe adverse GI reactions	Benefit: semaglutide (SQ)	• Thyroid C-cell tumors identified in rodents; human relevance not determined • Provide guidance on discontinuation prior to surgical procedures to mitigate potential for pulmonary aspiration with general anesthesia or deep sedation • Pancreatitis: acute pancreatitis has been reported, but causality has not been established; do not initiate if at high risk for pancreatitis, and discontinue if pancreatitis is suspected
Dual GIP and GLP-1 RA (SQ)	Very high	No	Loss (very high)	Under investigation	Benefit: tirzepatide	Potential benefit	• See labels of individual agents for dosage considerations for kidney function • No dose adjustment • Monitor kidney function when initiating or escalating doses in individuals with kidney impairment reporting severe adverse GI reactions	Potential benefit	• Biliary disease: evaluate for gallbladder disease if cholelithiasis or cholecystitis is suspected; avoid use in at-risk individuals • Ileus: reported, but risk level is not well established • Diabetic retinopathy: close monitoring of retinopathy in those at high risk (older individuals and those with longer duration of T2D [≥10 years]) • Nonarteritic anterior ischemic optic neuropathy (NAION) reported (rare incidence); monitor for NAION during eye examinations • Impact on drug absorption: orally administered drug absorption may be impaired during dose titration (including oral contraceptives) • GI side effects: counsel on potential for GI side effects; provide guidance on dietary modifications to mitigate GI side effects (reduction in meal size, mindful eating practices [e.g., stop eating once full], decreasing intake of high-fat or spicy food); consider slower dose titration for those experiencing GI challenges; not recommended for individuals with gastroparesis
DPP-4 inhibitors (oral)	Intermediate	No	Neutral	Neutral	Neutral (potential risk: saxagliptin)	Neutral	• Dose adjustment required based on kidney function (sitagliptin, saxagliptin, alogliptin) • No dose adjustment required for linagliptin	Unknown	• Pancreatitis has been reported but causality has not been established; discontinue if pancreatitis is suspected • Postmarketing concerns: about joint pain (consider discontinuing if debilitating and other treatment options are feasible) and bullous pemphigoid (discontinue if suspected); reversible upon discontinuation
Pioglitazone (oral)	High	No	Gain	Potential benefit	Increased risk	Neutral	• No dose adjustment required • Generally not recommended in kidney impairment due to potential for fluid retention	Potential benefit	• Increased risk of HF and fluid retention; do not use in setting of HF • Risk of bone fractures • Bladder cancer: do not use in individuals with active bladder cancer, and use caution in those with prior history of bladder cancer; association observed with higher cumulative exposure (e.g., longer duration, higher doses)
Sulfonylureas (2nd generation) (oral)	High	Yes	Gain	Neutral	Neutral	Neutral	• Glyburide: generally not recommended in CKD • Glipizide and glimepiride: initiate conservatively to avoid hypoglycemia	Unknown	• FDA Special Warning on increased risk of CV mortality based on studies of an older sulfonylurea (tolbutamide); glimepiride shown to be CV safe (see text) • Use with caution in individuals at risk for hypoglycemia, particularly if in combination with insulin

CKD, chronic kidney disease; CV, cardiovascular; DKA, diabetic ketoacidosis; DPP-4, dipeptidyl peptidase 4; eGFR, estimated glomerular filtration rate; FDA, U.S. Food and Drug Administration; GI, gastrointestinal; GIP, glucose-dependent insulinotropic polypeptide; GLP-1 RA, glucagon-like peptide 1 receptor agonist; HF, heart failure; MACE, major adverse cardiovascular events; MASH, metabolic dys- function-associated steatohepatitis; SGLT2, sodium–glucose cotransporter 2; SQ, subcutaneous; T2D, type 2 diabetes. *For agent-specific dosing recommendations, please refer to manufacturers.

Figure 11: Intensifying to injectable therapies in type 2 diabetes.



1. Consider insulin as the first injectable if symptoms of hyperglycemia are present, when A1C or blood glucose levels are very high (i.e., A1C >10% [>86 mmol/mol] or blood glucose ≥300 mg/dL [216.7 mmol/L]), or when a diagnosis of type 1 diabetes is a possibility.
2. When selecting GLP-1 RAs, consider individual preference, glycemic lowering, weight-lowering effect, and frequency of injection. If CVD is present, consider GLP-1 RA with proven CVD benefit; oral or injectable GLP-1 RAs are appropriate.
3. For people on GLP-1 RA and basal insulin combination, consider use of a fixed-ratio combination product (IDegLira or iGlarLixi).
4. Consider switching from evening NPH to a basal analog if the individual develops hypoglycemia and/or frequently forgets to administer NPH in the evening and would be better managed with a morning dose of a long-acting basal insulin. Consider dosing NPH in the morning for steroid-induced hyperglycemia.
5. Prandial insulin options include injectable rapid- and ultra-rapid-acting analog insulins, injectable short-acting human insulin, or inhaled human insulin.
6. If adding prandial insulin to NPH, consider initiation of a self-mixed or premixed insulin plan to decrease the number of injections required.

CGM, continuous glucose monitoring; DSMES, diabetes self-management education and support; FPG, fasting plasma glucose; GLP-1 RA, glucagon-like peptide 1 receptor agonist; GIP, glucose-dependent insulinotropic polypeptide; PPG, postprandial glucose.

9. CARDIOVASCULAR DISEASE AND RISK MANAGEMENT: STANDARDS OF CARE IN DIABETES–2026

Diabetes Care 2026;49(Suppl. 1):S216–S245

HYPERTENSION AND BLOOD PRESSURE MANAGEMENT

Screening and Diagnosis

Recommendations

- Blood pressure should be measured at every routine clinical visit, or at least every 6 months. Individuals found to have elevated blood pressure without a diagnosis of hypertension (systolic blood pressure 120–129 mmHg and diastolic blood pressure <80 mmHg) should have blood pressure confirmed using multiple readings, including measurements on a separate day, to diagnose hypertension. **A** Hypertension is defined as a systolic blood pressure ≥130 mmHg or a diastolic blood pressure ≥80 mmHg based on an average of two or more measurements obtained on two or more occasions. **A** Individuals with blood pressure ≥180/110 mmHg and cardiovascular disease could be diagnosed with hypertension at a single visit. **E**
- Counsel all people with hypertension and diabetes to monitor their blood pressure at home after appropriate education. **A**

Treatment goals

Recommendations

- For people with diabetes and hypertension, blood pressure goals should be individualized through a shared decision-making process that addresses cardiovascular risk, potential adverse effects of antihypertensive medications, and individual preferences. **B**
- If it can be safely attained, the on-treatment blood pressure goal is <130/80 mmHg; a systolic blood pressure goal <120 mmHg should be encouraged in individuals with high cardiovascular or kidney risk. **A**

Treatment strategies

Lifestyle Intervention

Recommendations

- For people with diabetes and blood pressure >120/80 mmHg, advise lifestyle behaviors including weight loss when indicated, a Dietary Approaches to Stop Hypertension (DASH)–style eating pattern including reducing sodium, limiting or avoiding alcohol consumption, increased physical activity, and smoking cessation. **A**

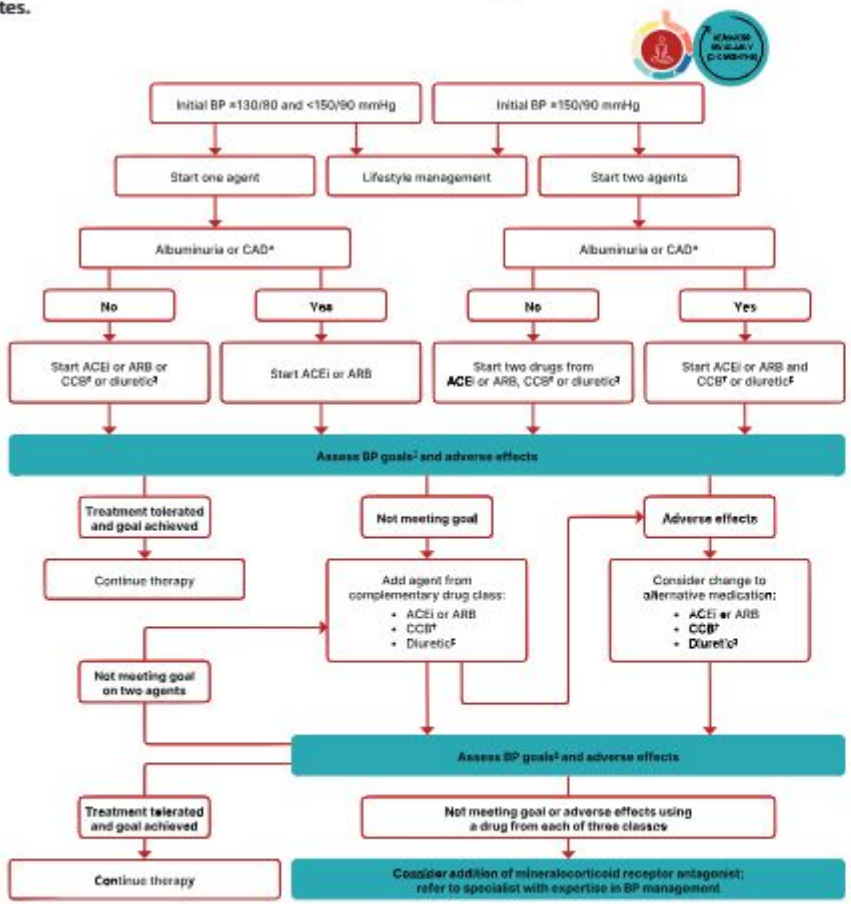
Pharmacologic Interventions

Recommendations

- In individuals with confirmed office-based blood pressure ≥130/80 mmHg, pharmacologic therapy should be initiated and titrated to achieve their individualized blood pressure goal. **A**
- Individuals with confirmed officebased blood pressure ≥150/90 mmHg should, in addition to lifestyle therapy, have prompt initiation and timely titration of two drugs or a single-pill combination of drugs for hypertension that have also been demonstrated to reduce cardiovascular events in people with diabetes. **A**
- Treatment for hypertension should include drug classes demonstrated to reduce cardiovascular events in people with diabetes. **A** ACE inhibitors or angiotensin receptor blockers (ARBs) are recommended first-line therapy for hypertension in people with diabetes and albuminuria or coronary artery disease. **A**

- Multiple-drug therapy is generally required to achieve blood pressure goals. However, avoid any combination of ACE inhibitors, ARBs (including ARBs and neprilysin inhibitors), and direct renin inhibitors. **A**
- In nonpregnant people with diabetes and hypertension, either an ACE inhibitor or ARB is recommended for those with moderately increased albuminuria (UACR 30–299 mg/g creatinine) **B** and is strongly recommended for those with severely increased albuminuria (UACR ≥300 mg/g creatinine) and/or estimated glomerular filtration rate (eGFR) <60 mL/min/1.73 m^2 to maximally tolerated dose to prevent the progression of kidney disease and reduce cardiovascular events. **A** If one class is not tolerated, the other should be substituted. **B**
- Monitor for drop in eGFR and for increase in serum potassium levels at initiation and periodically as clinically appropriate when ACE inhibitors, ARBs, and mineralocorticoid receptor antagonists (MRAs) are used. **B** Monitor for hypokalemia when diuretics are used at routine visits and 7–14 days after initiation or after a dose change and periodically as clinically appropriate. **B**
- In sexually active individuals of childbearing potential who are not using reliable contraception, avoid ACE inhibitors, ARBs, MRAs, direct renin inhibitors, and neprilysin inhibitors, as they are contraindicated in pregnancy. **A**

Figure 11: Recommendations for the treatment of confirmed hypertension in nonpregnant people with diabetes.



*An ACE inhibitor (ACEi) or angiotensin receptor blocker (ARB) is suggested for the treatment of hypertension in people with coronary artery disease (CAD) or urine albumin-tocreatinine ratio 30–299 mg/g creatinine and is strongly recommended for individuals with urine albumin-to-creatinine ratio ≥300 mg/g creatinine. †Dihydropyridine calcium channel blocker (CCB). ‡Thiazide-like diuretic; long-acting agents shown to reduce cardiovascular events, such as chlorthalidone and indapamide, are preferred. §If it can be safely attained, the on-treatment blood pressure goal is <130/80 mmHg; a systolic blood pressure goal <120 mmHg should be encouraged in individuals with high cardiovascular or kidney risk. BP, blood pressure.

RESISTANT HYPERTENSION

Recommendations

- Individuals with hypertension who are not meeting blood pressure goals on three classes of antihypertensive medications (including a diuretic) should be considered for MRA therapy. **A**

LIPID MANAGEMENT

Lifestyle Intervention

Recommendations

- Lifestyle modification focusing on weight loss (if indicated); application of a Mediterranean or DASH eating pattern; reduction of saturated fat and trans fat; increase of dietary n-3 fatty acids, soluble fiber, and plant stanol and sterol intake; and increased physical activity should be recommended to improve the lipid profile and reduce the risk of developing atherosclerotic cardiovascular disease (ASCVD) in people with diabetes. **A**
- Intensify lifestyle therapy and optimize glycemic management for people with diabetes with elevated triglyceride levels (≥150 mg/dL [≥1.7 mmol/L]) and/or low HDL cholesterol (<40 mg/dL [<1.0 mmol/L] for men and <50 mg/dL [<1.3 mmol/L] for women). **C**

Ongoing Therapy and Monitoring With Lipid Panel

Recommendations

- In adults with prediabetes or diabetes not taking statins or other lipidlowering therapy, it is reasonable to obtain a lipid profile at the time of diagnosis, at an initial medical evaluation, annually thereafter, or more frequently if indicated. **E**
- Obtain a lipid profile at initiation of statins or other lipid-lowering therapy, 4–12 weeks after initiation or a change in dose, and annually thereafter, as it facilitates monitoring the response to therapy and informs medication-taking behavior. **A**

STATIN TREATMENT

Primary Prevention

Recommendations

- For people with diabetes aged 40–75 years without ASCVD, use moderate-intensity statin therapy in addition to lifestyle therapy. **A**
- For people with diabetes aged 20–39 years with additional ASCVD risk factors, it may be reasonable to initiate statin therapy in addition to lifestyle therapy. **C**
- For people with diabetes aged 40–75 years at higher cardiovascular risk, including those with one or more additional ASCVD risk factors, highintensity statin therapy is recommended to reduce LDL cholesterol by ≥50% of baseline and to obtain an LDL cholesterol goal of <70 mg/dL (<1.8 mmol/L). **A**

- For people with diabetes aged 40–75 years at higher cardiovascular risk, especially those with multiple additional ASCVD risk factors and an LDL cholesterol ≥70 mg/dL (≥1.8 mmol/L), it may be reasonable to add ezetimibe or a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor to maximum tolerated statin therapy. **B**
- In adults with diabetes aged >75 years already on statin therapy, it is reasonable to continue statin treatment. **B**
- In adults with diabetes aged >75 years, it may be reasonable to initiate moderate-intensity statin therapy after discussion of potential benefits and risks. **C**
- In people with diabetes intolerant to statin therapy, treatment with bempedoic acid is recommended to reduce cardiovascular event rates as an alternative cholesterol-lowering plan. **A**
- In most circumstances, lipidlowering agents should be stopped prior to conception and avoided in sexually active individuals of childbearing potential who are not using reliable contraception. **B** In some circumstances (e.g., familial hypercholesterolemia, familial hypertriglyceridemia, prior ASCVD event, or history of pancreatitis), lipid-lowering therapy may be continued when the benefits outweigh risks. **E**

Secondary Prevention

Recommendations

- For people of all ages with diabetes and ASCVD, high-intensity statin therapy should be added to lifestyle therapy. **A**
- For people with diabetes and ASCVD, treatment with high-intensity statin therapy is recommended to obtain an LDL cholesterol reduction of ≥50% from baseline and an LDL cholesterol goal of <55 mg/dL (<1.4 mmol/L). Addition of ezetimibe or a PCSK9 inhibitor with proven benefit in this population is recommended if this goal is not achieved on maximum tolerated statin therapy. **B**
- For individuals who do not tolerate the intended statin intensity, the maximum tolerated statin dose should be used. **E**
- For people with diabetes and ASCVD intolerant to statin therapy, PCSK9 monoclonal antibody therapy, A bempedoic acid therapy, **A** or PCSK9 inhibitor therapy with inclisiran siRNA E should be considered as an alternative cholesterol-lowering therapy.

Table 18: High-intensity and moderate-intensity statin therapy

High-intensity statin therapy (lowers LDL cholesterol by ≥50%)	Moderate-intensity statin therapy (lowers LDL cholesterol by 30–49%)
Atorvastatin 40–80 mg	Atorvastatin 10–20 mg
Rosuvastatin 20–40 mg	Rosuvastatin 5–10 mg
	Simvastatin 20–40 mg
	Pravastatin 40–80 mg
	Lovastatin 40 mg
	Fluvastatin XL 80 mg
	Pitavastatin 1–4 mg

Once-daily dosing. XL, extended release.

Treatment of Other Lipoprotein Fractions or Goals

Recommendations

- For individuals with fasting triglyceride levels ≥500 mg/dL (≥5.7 mmol/L), evaluate for secondary causes of hypertriglyceridemia and consider medical therapy to reduce the risk of pancreatitis. **C**
- In adults with hypertriglyceridemia (fasting triglycerides >150 mg/dL [>1.7 mmol/L] or nonfasting triglycerides >175 mg/dL [>2.0 mmol/L]), clinicians should address and treat lifestyle factors (obesity and metabolic syndrome), secondary factors (diabetes, chronic liver or kidney disease and/or nephrotic syndrome, and hypothyroidism), and medications that raise triglycerides. **C**
- In individuals with ASCVD or other cardiovascular risk factors on a statin with managed LDL cholesterol but elevated triglycerides (150–499 mg/dL [1.7–5.6 mmol/L]), the addition of icosapent ethyl can be considered to reduce cardiovascular risk. **B**

Other Combination Therapy

Recommendations

- In individuals receiving statin therapy, the addition of fibrate, niacin, or dietary supplements containing n-3 fatty acids is not recommended as they do not provide additional cardiovascular risk reduction. **A**

ANTIPLATELET AGENTS

Recommendations

- Use aspirin therapy (75–162 mg/day) as a secondary prevention strategy in those with diabetes and a history of ASCVD. **A**
- For individuals with ASCVD and documented aspirin allergy, clopidogrel (75 mg/day) should be used. **B**
- The length of treatment with dual antiplatelet therapy using low-dose aspirin and a P2Y12 inhibitor in individuals with diabetes after an acute coronary syndrome, acute ischemic stroke, or transient ischemic attack should be determined by an interprofessional team approach that includes a cardiovascular or neurological specialist, respectively. **E**
- Combination therapy with 81 mg aspirin daily plus 2.5 mg rivaroxaban twice daily should be considered for individuals with stable coronary and/or peripheral artery disease (PAD) and low bleeding risk to prevent major adverse limb and cardiovascular events. **A**
- Aspirin therapy (75–162 mg/day) may be considered as a primary prevention strategy in those with diabetes who are at increased cardiovascular risk after a comprehensive discussion with the individual on the benefits versus the comparable increased risk of bleeding. **A**

CARDIOVASCULAR DISEASE

Screening

Recommendations

- In asymptomatic individuals, routine screening for coronary artery disease is not recommended, as it does not improve outcomes as long as ASCVD risk factors are treated. **A**
- Consider investigations for coronary artery disease in the presence of any of the following: signs or symptoms of cardiac or associated vascular disease, including carotid bruits, transient ischemic attack, stroke, claudication, or PAD; or electrocardiographic abnormalities (e.g., pathological Q waves). **E**
- Adults with diabetes are at increased risk for the development of asymptomatic cardiac structural

or functional abnormalities (stage B heart failure) or symptomatic (stage C) heart failure. Consider screening adults with diabetes by measuring a natriuretic peptide (B-type natriuretic peptide [BNP] or N-terminal pro-BNP [NTproBNP]) to facilitate prevention of stage C heart failure. **B**

- In asymptomatic individuals with diabetes and abnormal natriuretic peptide levels, echocardiography is recommended to identify stage B heart failure. **A**
- In asymptomatic individuals with diabetes and age ≥65 years, microvascular disease in any location, or foot complications or any end-organ damage from diabetes, screening for PAD with ankle-brachial index testing is recommended if a PAD diagnosis would change management. **B**

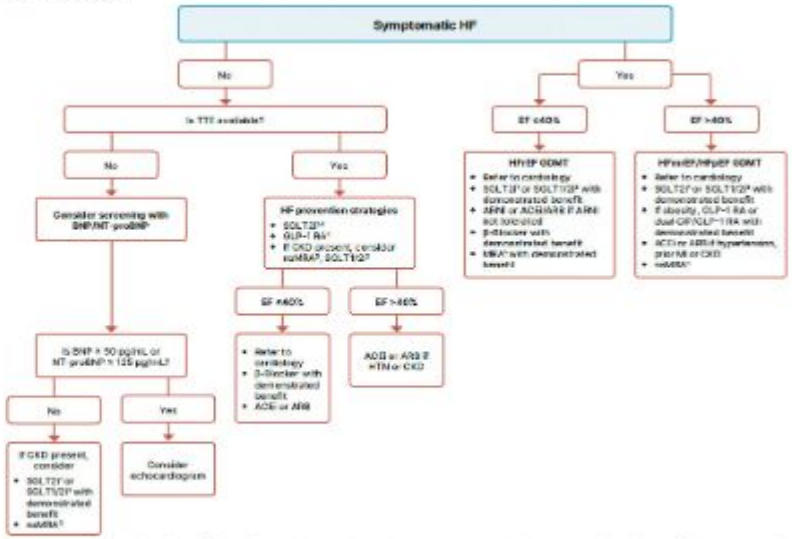
Treatment

Recommendations

- Among people with type 2 diabetes who have established ASCVD or chronic kidney disease (CKD), a sodium–glucose cotransporter 2 (SGLT2) inhibitor or glucagon-like peptide 1 receptor agonist (GLP-1 RA) with demonstrated cardiovascular disease benefit is recommended as part of the comprehensive cardiovascular risk reduction and/or glucose-lowering treatment plans. **A**
- In people with type 2 diabetes and established ASCVD or multiple ASCVD risk factors, or CKD, an SGLT2 inhibitor with demonstrated cardiovascular benefit is recommended to reduce the risk of cardiovascular events. **A**
- In people with type 2 diabetes and established ASCVD or multiple risk factors for ASCVD, or CKD, a GLP-1 RA with demonstrated cardiovascular benefit is recommended to reduce the risk of cardiovascular events. **A**
- In people with type 2 diabetes and established ASCVD or multiple risk factors for ASCVD, combined therapy with an SGLT2 inhibitor with demonstrated cardiovascular benefit and a GLP-1 RA with demonstrated cardiovascular benefit may be considered for additive reduction of the risk of adverse cardiovascular and kidney events. **B**
- In people with type 2 diabetes and established heart failure with either preserved or reduced ejection fraction, an SGLT2 inhibitor (including SGLT1/2 inhibitor) with proven benefit in this population is recommended to reduce the risk of worsening heart failure and cardiovascular death. **A**
- In people with type 2 diabetes and established heart failure with either preserved or reduced ejection fraction, an SGLT2 inhibitor with proven benefit in this population is recommended to improve quality of life. **A**
- For individuals with type 2 diabetes and CKD with albuminuria treated with maximum tolerated doses of ACE inhibitor or ARB, recommend treatment with a nonsteroidal MRA with demonstrated benefit to improve cardiovascular outcomes and reduce the risk of CKD progression. **A**
- In individuals with diabetes aged ≥55 years with established ASCVD or multiple ASCVD risk factors, ACE inhibitor or ARB therapy is recommended to reduce the risk of cardiovascular events. **A**
- In individuals with diabetes and asymptomatic (stage B) heart failure, an interprofessional approach to optimize guideline-directed medical therapy, which should include a cardiovascular disease specialist, is recommended to reduce the risk for progression to symptomatic (stage C) heart failure. **A**
- In individuals with diabetes and asymptomatic (stage B) heart failure, ACE inhibitors or ARBs and β-blockers are recommended to reduce the risk for progression to symptomatic (stage C) heart failure. **A**

- In individuals with type 2 diabetes and asymptomatic (stage B) heart failure or with high risk of or established cardiovascular disease, treatment with an SGLT inhibitor with proven heart failure prevention benefit **A** or a GLP-1 RA with heart failure prevention benefit **B** is recommended to reduce the risk of hospitalization for heart failure.
- 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.
- In adults with type 2 diabetes, obesity, and symptomatic 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**
- In individuals with type 2 diabetes and CKD, recommend treatment with a nonsteroidal MRA with demonstrated benefit to reduce the risk of hospitalization for heart failure. **A**
- In individuals with diabetes, guideline-directed medical therapy for myocardial infarction and symptomatic stage C heart failure is recommended with ACE inhibitors or ARBs (including ARBs and neprilysin inhibitors), MRAs, β-blockers, and SGLT2 inhibitors. **A**
- In individuals with diabetes and symptomatic stage C heart failure with ejection fraction >40%, a nonsteroidal MRA with proven benefit in reducing worsening heart failure events is recommended. **A** A nonsteroidal MRA should not be used with an MRA.
- In people with type 2 diabetes with stable heart failure, metformin may be continued for glucose lowering if eGFR remains >30 mL/min/1.73 m^2 but should be avoided in unstable or hospitalized individuals with heart failure. **B**
- Educate individuals with diabetes who are at risk for developing diabetic ketoacidosis and who are treated with SGLT inhibition on the risks and signs of ketoacidosis and methods of risk mitigation management, provide them with appropriate tools for ketone measurement (i.e., serum β-hydroxybutyrate), and discourage a ketogenic eating pattern. **E**

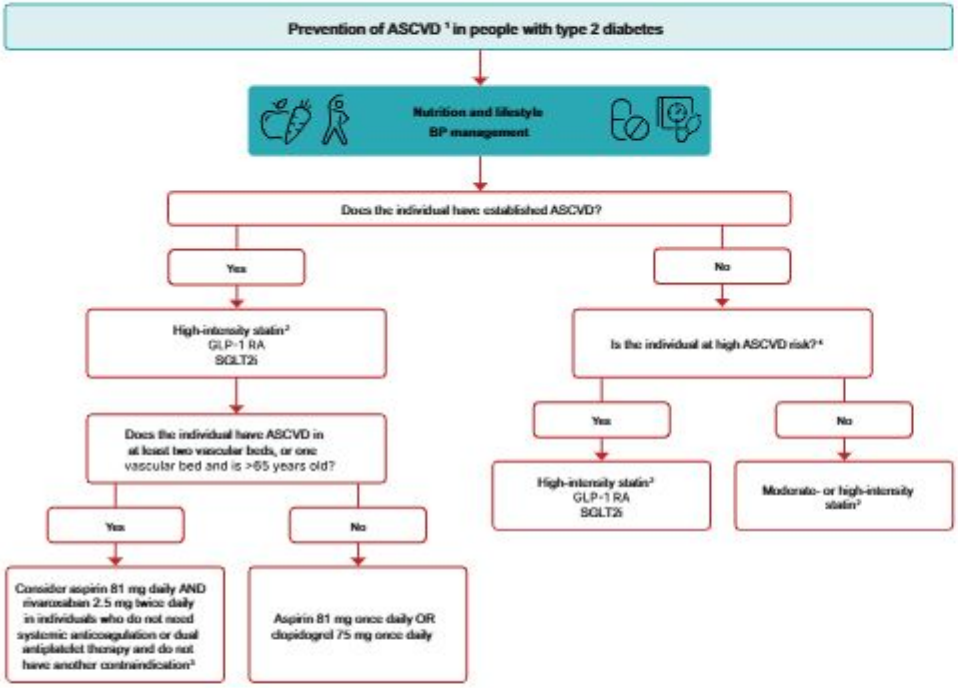
Figure 12: Overview of recommendations for the prevention and treatment of symptomatic heart failure in people with diabetes.



SGLT2i parameters: if eGFR ≥ 20 mL/min/1.73 m^2 SGLT1/2i can be used as an alternative to SGLT2i if eGFR ≥ 30 mL/min/1.73 m^2 If UACR 30mg/g, K+<5.0 mEq/L (< 5.0 mmol/L) The absolute benefit of SGLT2i and GLP-1RA in preventing symptomatic HF will be greatest among those at the highest absolute risk. If eGFR ≥30 mL/min/1.73 m^2, K+<5.0 mEq/L (< 5.0 mmol/L)If eGFR ≥25 mL/min/1.73 m^2, K+<5.0 mEq/L (< 5.0 mmol/L)

ACEI, ACE inhibitor; ARB, angiotensin receptor blocker; ARNI, angiotensin receptor neprilysin inhibitor; BNP, B-type natriuretic peptide; NT-proBNP, N-terminal pro-B–type natriuretic peptide; CKD, chronic kidney disease; CVD, cardiovascular disease; EF, ejection fraction; eGFR, estimated glomerular filtration rate; GDMT, guideline-directed medical therapy; GIP/GLP-1 RA, glucose-dependent insulinotropic polypeptide and glucagon-like peptide-1 receptor agonist; GLP-1 RA, glucagon-like peptide-1 receptor agonist; HF, heart failure; HFmrEF, heart failure with mildly reduced ejection fraction; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HTN, hypertension; MI, myocardial infarction; MRA, mineralocorticoid receptor antagonist; nsMRA, nonsteroidal mineralocorticoid receptor antagonist; SGLT1/2i, sodium–glucose cotransporter 1 and 2 inhibitor; SGLT2i, sodium–glucose cotransporter 2 inhibitor; TTE, transthoracic echocardiography; UACR, urine albumin-to-creatinine ratio.

Figure 13: Approach to prevent ASCVD in people with type 2 diabetes



1. ASCVD is defined as a history of an acute coronary syndrome or myocardial infarction, angina, coronary heart disease with or without revascularization, other arterial revascularization, stroke, or peripheral artery disease assumed to be atherosclerotic in origin.
2. Non-statins with demonstrated benefit should be considered in those with statin intolerance.
3. Consider low-dose rivaroxaban in people with atherosclerotic disease in at least two vascular beds, or in one bed and are older than 65 years, who do NOT have an increased risk of bleeding, recent (<1 year) stroke, renal failure, LVEF <30%, or need for dual antiplatelet therapy or systemic anticoagulation.
4. Individuals at high risk for ASCVD include those with end-organ damage such as left ventricular hypertrophy or retinopathy or with multiple CV risk factors (e.g., older age, hypertension, smoking, dyslipidemia, CKD, and obesity).
5. Low-dose pioglitazone may be better tolerated and similarly effective as higher doses.

ASCVD, atherosclerotic cardiovascular disease; BP, blood pressure; CKD, chronic kidney disease; CV, cardiovascular; GLP-1 RA, glucagon-like peptide 1 receptor agonist; LVEF, left ventricle ejection fraction; SGLT2i, sodium–glucose cotransporter 2 inhibitor.

10. CHRONIC KIDNEY DISEASE AND RISK MANAGEMENT: STANDARDS OF CARE IN DIABETES–2026

Diabetes Care 2026;49(Suppl. 1):S246–S260

ASSESSMENT OF ALBUMINURIA AND ESTIMATED GLOMERULAR FILTRATION RATE

Recommendations

- Assess kidney function with random urine albumin-to-creatinine ratio (UACR) and estimated glomerular filtration rate (eGFR) at least annually in people with type 1 diabetes with duration of ≥5 years and in all people with type 2 diabetes regardless of treatment. **B**
- In people with chronic kidney disease (CKD), monitor urinary albumin (e.g., spot UACR) and eGFR 1–4 times per year depending on the stage of kidney disease. **B**

SURVEILLANCE

Recommendations

- Aim to reduce urinary albumin by ≥30% in people with CKD and albuminuria ≥300 mg/g to slow CKD progression. **B**

INTERVENTIONS

Nutrition

Recommendations

- For people with CKD stage G3 or higher, protein intake should be 0.8 g/kg body weight per day, as for the general population. **A**
- For individuals on dialysis, protein intake of 1.0–1.2 g/kg/day should be considered, since protein energy wasting is a major problem for some individuals on dialysis. **B**

Glycemic Goals

Recommendations

- Optimize glucose management to reduce the risk or slow the progression of CKD. **A**

Blood Pressure and Use of ACE Inhibitors and Angiotensin Receptor Blockers

Recommendations

- If it can be safely attained, the on-treatment blood pressure goal for people with CKD is <130/80 mmHg; a systolic blood pressure goal <120 mmHg and/or reduction in blood pressure variability should be encouraged. **A**
- In nonpregnant people with diabetes and hypertension, either an ACE inhibitor or an angiotensin receptor blocker (ARB) is recommended for those with moderately increased albuminuria (UACR 30–299 mg/g creatinine) **B** and is strongly recommended for those with severely increased albuminuria (UACR ≥300 mg/g creatinine) and/or eGFR <60 mL/min/1.73 m^2 to maximally tolerated dose to prevent the progression of kidney disease and reduce cardiovascular events. **A** If one class is not tolerated, the other should be substituted. **B**
- Monitor for drop in eGFR and increase in serum potassium levels at initiation and periodically as clinically appropriate when ACE inhibitors, ARBs, and mineralocorticoid receptor antagonists (MRAs) are used. **B** Monitor for hypokalemia when diuretics are used at routine visits and 7–14 days after initiation or after a dose change and periodically as clinically appropriate. **B**

- An ACE inhibitor or an ARB is not recommended for the primary prevention of CKD in people with diabetes who have normal blood pressure, normal UACR (<30 mg/g creatinine), and normal eGFR. **A**
- Continue renin-angiotensin system blockade for mild to moderate increases in serum creatinine (≤30%) in individuals who have no signs of extracellular fluid volume depletion. **A**

Direct Kidney Effects of Glucose-Lowering Medications

Recommendations

- For people with type 2 diabetes and CKD, use of a sodium–glucose cotransporter 2 (SGLT2) inhibitor with demonstrated benefit to reduce CKD progression and cardiovascular events is recommended. SGLT2 inhibitors should be initiated in individuals with eGFR ≥20 mL/min/1.73 m^2 but can safely continue until kidney failure. **A**
- To reduce kidney disease progression and cardiovascular risk in people with type 2 diabetes and CKD, a glucagon-like peptide 1 agonist with demonstrated benefit in this population is recommended. **A**

Kidney and Cardiovascular Outcomes of Mineralocorticoid Receptor Antagonists in Chronic Kidney Disease.

Recommendations

- To reduce CKD progression and cardiovascular events in people with CKD and albuminuria, a nonsteroidal MRA that has been shown to be effective in clinical trials is recommended (if eGFR is ≥25 mL/min/1.73 m^2). Potassium levels should be monitored 1 month after initiation. **A**

Combination Therapy Considerations to Optimize Kidney and Cardiovascular Risk Reduction.

Recommendations

- Simultaneous initiation of an SGLT2 inhibitor and a nonsteroidal MRA (finerenone) can be considered in adults with type 2 diabetes and UACR ≥100 mg/g with eGFR 30–90 mL/min/1.73 m^2 on a reninangiotensin system inhibitor due to evidence of safety and beneficial effects on albuminuria. **B**

Use of Kidney-Protective Medications in Pregnancy.

Recommendations

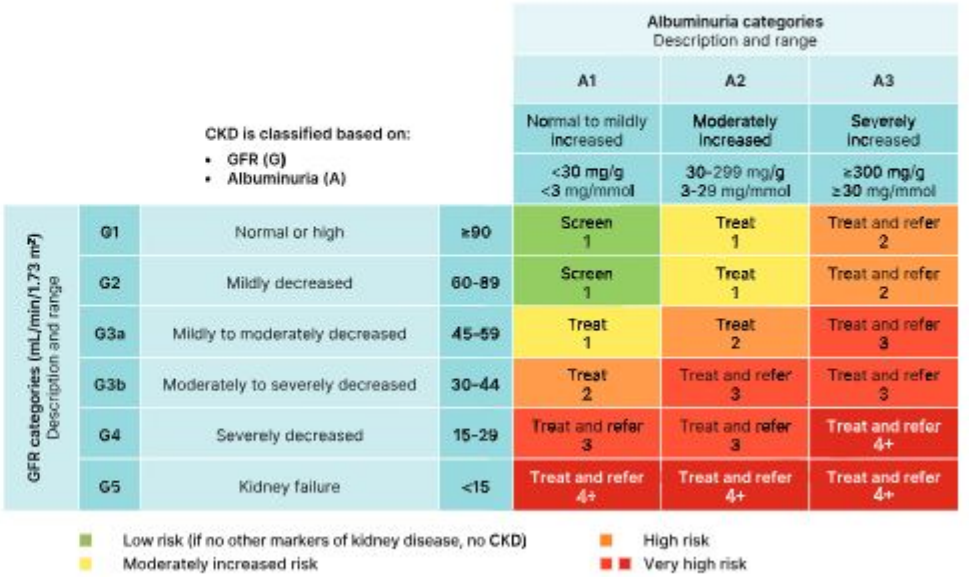
- Kidney-protective medications that are potentially harmful in pregnancy should be avoided in sexually active individuals of childbearing potential who are not using reliable contraception and, if used, should be switched prior to conception to kidney-protective medications considered safer during pregnancy. **B**

Treatment for Severe Chronic Kidney Disease and Kidney Failure

Recommendations

- Individuals with eGFR <20 mL/min/1.73 m^2 and not on dialysis can be safely continued on SGLT2 inhibitors to reduce the risk of CKD progression B and for cardiovascular benefits. **C**
- Individuals on dialysis can be safely initiated or continued on GLP- 1–based therapy that is not dependent on kidney clearance to reduce cardiovascular risk and mortality. **C**

Figure 14. Risk of CKD progression, cardiovascular disease risk, and mortality; frequency of visits; and referral to nephrology according to GFR and albuminuria.



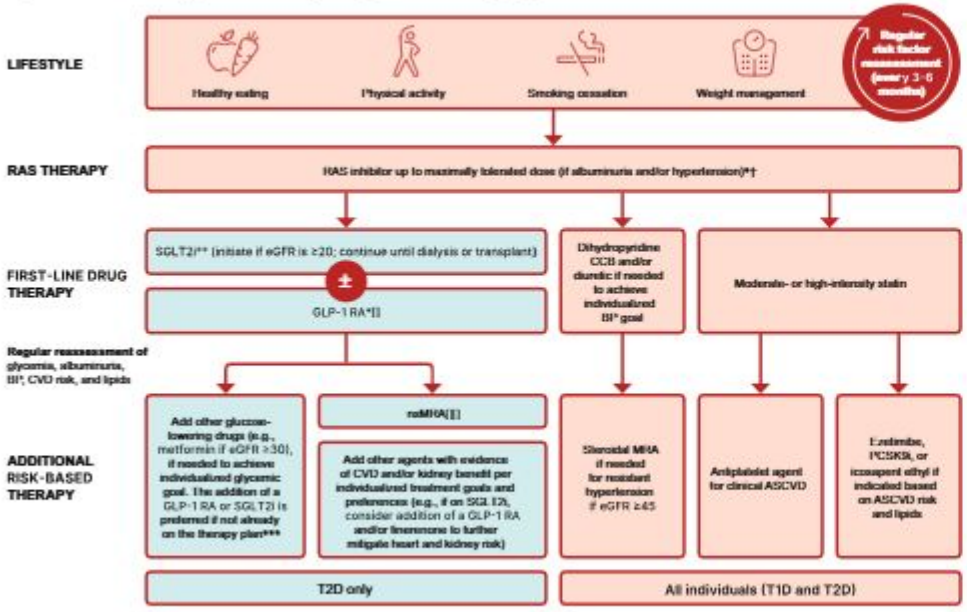
The numbers in the boxes are a guide to the frequency of screening or monitoring (number of times per year). Green reflects no evidence of CKD by estimated GFR or albuminuria, with screening indicated once per year. For monitoring of prevalent CKD, suggested monitoring varies from once per year (yellow) to four times or more per year (i.e., every 1–3 months [deep red]) according to risks of CKD progression and CKD complications (e.g., cardiovascular disease, anemia, and hyperparathyroidism). These are general parameters based only on expert opinion and underlying comorbid conditions, and disease state must be taken into account, as should the likelihood of impacting a change in management for any individual. CKD, chronic kidney disease; GFR, glomerular filtration rate.

Table 19: Screening for selected complications of chronic kidney disease

Complication	Physical and laboratory evaluation
Blood pressure >130/80 mmHg	Blood pressure, weight, BMI
Volume overload	History, physical examination, weight
Electrolyte abnormalities	Serum electrolytes
Metabolic acidosis	Serum electrolytes
Anemia	Hemoglobin; iron, iron saturation, ferritin testing if indicated
Metabolic bone disease	Serum calcium, phosphate, PTH, vitamin 25(OH)D

Complications of chronic kidney disease (CKD) generally become prevalent when estimated glomerular filtration rate falls below 60 mL/min/1.73 m2 (stage G3 CKD or greater) and become more common and severe as CKD progresses. Evaluation of elevated blood pressure and volume overload should occur at every clinical contact possible; laboratory evaluations are generally indicated every 6–12 months for stage G3 CKD, every 3–5 months for stage G4 CKD, and every 1–3 months for stage G5 CKD, or as indicated to evaluate symptoms or changes in therapy. 25(OH)D, 25-hydroxyvitamin D; PTH, parathyroid hormone.

Figure 15: Holistic approach for improving outcomes in people with diabetes and CKD.



*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.

Icons presented indicate the following benefits: BP cuff, BP lowering; glucose meter, glucose lowering; heart, cardioprotection; kidney, kidney protection; scale, weight management. eGFR is presented in units of mL/min/1.73 m2. †ACEi or ARB (at maximal tolerated doses) should be first-line therapy for hypertension when albuminuria is present. Otherwise, dihydropyridine calcium channel blocker or diuretic can also be considered; all three classes are often needed to attain BP targets. †Finerenone is currently the only nsMRA with proven clinical kidney and cardiovascular benefits. ACEi, angiotensin-converting enzyme inhibitor; ACR, albumin-to-creatinine ratio; ARB, angiotensin receptor blocker; ASCVD, atherosclerotic cardiovascular disease; BP, blood pressure; CCB, calcium channel blocker; CVD, cardiovascular disease; eGFR, estimated glomerular filtration rate; GLP-1 RA, glucagon-like peptide 1 receptor agonist; HTN, hypertension; MRA, mineralocorticoid receptor antagonist; nsMRA, nonsteroidal mineralocorticoid receptor antagonist; PCSK9i, proprotein convertase subtilisin/kexin type 9 inhibitor; RAS, renin-angiotensin system; SGLT2i, sodium–glucose cotransporter 2 inhibitor; T1D, type 1 diabetes; T2D, type 2 diabetes.

11. RETINOPATHY, NEUROPATHY, AND FOOT CARE: STANDARDS OF CARE IN DIABETES–2026

Diabetes Care 2026;49(Suppl. 1):S261–S276

DIABETIC RETINOPATHY

Recommendations

- Implement strategies to help people with diabetes reach glycemic goals to reduce the risk or slow the progression of diabetic retinopathy. **A**
- Implement strategies to help people with diabetes reach blood pressure and lipid goals to reduce the risk or slow the progression of diabetic retinopathy. **A**

Screening

Recommendations

- Adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist 5 years after the onset of diabetes. **B**
- People with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis. **B**
- If there is no evidence of retinopathy from one or more annual eye exams and glycemic indicators are within the goal range, then screening every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sightthreatening, then examinations by an ophthalmologist will be required more frequently. **B**
- Programs that use retinal photography with remote reading or the use of U.S. Food and Drug Administration–approved artificial intelligence algorithms to improve access to diabetic retinopathy screening are appropriate screening strategies for diabetic retinopathy. Such programs need to provide pathways for timely referral for a comprehensive eye examination when indicated. **B**
- Counsel individuals of childbearing potential with preexisting type 1 or type 2 diabetes who are planning pregnancy or who are pregnant on the risk of development and/or progression of diabetic retinopathy. **B**
- Individuals with preexisting type 1 or type 2 diabetes should receive an eye exam before pregnancy as well as in the first trimester and may need to be monitored every trimester and for 1 year postpartum as indicated by the degree of retinopathy. **B**

Treatment

Recommendations

- Promptly refer individuals with any level of diabetic macular edema, moderate or worse nonproliferative diabetic retinopathy (a precursor of proliferative diabetic retinopathy [PDR]), or any PDR to an ophthalmologist who is knowledgeable and experienced in the management of diabetic retinopathy. **A**
- Panretinal laser photocoagulation therapy is indicated to reduce the risk of vision loss in individuals with high-risk PDR and, in some cases, severe nonproliferative diabetic retinopathy. **A**
- Intravitreous injections of anti–vascular endothelial growth factor (antiVEGF) are a reasonable alternative to traditional panretinal laser photocoagulation for some individuals with PDR and also reduce the risk of vision loss in these individuals. **A**
- Intravitreous injections of antiVEGF are indicated as first-line treatment for most eyes with diabetic macular edema that involves the foveal center and impairs visual acuity. **A**
- Macular focal/grid photocoagulation and intravitreal injections of corticosteroid are reasonable

treatments in eyes with persistent diabetic macular edema despite previous anti-VEGF therapy or eyes that are not candidates for this first-line approach. **A**

- The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as aspirin does not increase the risk of retinal hemorrhage. **A**

Visual Rehabilitation

Recommendations

- People who experience diabetesrelated vision loss should be counseled on the availability and scope of vision rehabilitation care and provided, or referred for, a comprehensive evaluation of their visual impairment by a practitioner experienced in vision rehabilitation. **E**
- People with diabetes-related vision loss should receive educational materials and resources for eye care support in addition to self-management education (e.g., glycemic management and hypoglycemia awareness). **E**

NEUROPATHY

Screening

Recommendations

- All people with diabetes should be assessed for diabetic peripheral neuropathy starting at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes and at least annually thereafter. **B**
- Assessment for distal symmetric polyneuropathy should include a careful history and assessment of either temperature or pinprick sensation (small-fiber function) and vibration sensation using a 128-Hz tuning fork (large-fiber function). All people with diabetes should have annual 10-g monofilament testing to identify feet at risk for ulceration and amputation. **B**
- Symptoms and signs of autonomic neuropathy should be assessed in people with diabetes starting at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes, and at least annually thereafter, and with evidence of other microvascular complications, particularly kidney disease and diabetic peripheral neuropathy. Screening can include asking about orthostatic dizziness, syncope, early satiety, erectile dysfunction, changes in sweating patterns, or dry cracked skin in the extremities. Signs of autonomic neuropathy include orthostatic hypotension, a resting tachycardia, or evidence of peripheral dryness or cracking of skin. **E**

Treatment

Recommendations

- Optimize glucose management to prevent or delay the development of neuropathy in people with type 1 diabetes **A** and to slow the progression of neuropathy in people with type 2 diabetes. **C** Optimize weight, blood pressure, and lipid management to reduce the risk or slow the progression of diabetic neuropathy. **B**
- Assess and treat pain related to diabetic peripheral neuropathy B and symptoms of autonomic neuropathy to improve quality of life. **E**
- Gabapentinoids, serotoninnorepinephrine reuptake inhibitors, tricyclic antidepressants, and sodium channel blockers are recommended as initial pharmacologic treatments for neuropathic pain in diabetes. **A** Combinations of these medications can provide additional relief of neuropathic pain. **A** Opioids, including tramadol and tapentadol, should not be used for neuropathic pain treatment in diabetes given the potential for adverse events except in rare circumstances. **B**

FOOT CARE

Recommendations

- Perform a comprehensive foot evaluation at least annually to identify risk factors for ulcers and amputations. **A**
- The examination should include inspection of the skin, assessment of foot deformities, neurological assessment (10-g monofilament testing or Ipswich touch test with at least one additional assessment: pinprick, temperature, or vibration), and vascular assessment, including pulses in the legs and feet. **B**
- Individuals with evidence of sensory loss or prior ulceration or amputation should have their feet inspected at every visit. **A**
- Obtain a prior history of ulceration, amputation, Charcot foot, angioplasty or vascular surgery, cigarette smoking, retinopathy, and renal disease and assess current symptoms of neuropathy (e.g., pain, burning, numbness) and vascular disease (e.g., leg fatigue, claudication). **B**
- Initial screening for peripheral artery disease (PAD) should include assessment of lower-extremity pulses, capillary refill time, rubor on dependency, pallor on elevation, and venous filling time. Individuals with a history of leg fatigue, claudication, and rest pain relieved with dependency or decreased or absent pedal pulses should be referred for ankle-brachial index with toe pressures and for further vascular assessment as appropriate. **B**
- An interprofessional approach facilitated by a podiatrist in conjunction with other appropriate team members is recommended for individuals with foot ulcers and high-risk feet (e.g., those on dialysis, those with Charcot foot, those with a history of prior ulcers or amputation, and those with PAD). **B**
- Refer individuals who smoke and have a history of prior lower-extremity complications, loss of protective sensation (LOPS), structural abnormalities, or PAD to foot care specialists for ongoing preventive care and lifelong surveillance. B These individuals should also be provided with information on the importance of smoking cessation and referred for counseling on smoking cessation. **A**
- Provide general preventive foot self-care education to all people with diabetes, including those with LOPS, on appropriate ways to examine their feet (palpation or visual inspection with an unbreakable mirror) for daily surveillance of early foot problems. **B**
- The use of specialized therapeutic footwear is recommended for people with diabetes at high risk for ulceration, including those with LOPS, foot deformities, ulcers, callous formation, poor peripheral circulation, or history of amputation. **B**
- For chronic diabetic foot ulcers that have failed to heal with optimal standard care alone, adjunctive treatment with randomized controlled trial–proven advanced agents should be considered (e.g., negative-pressure wound therapy, several skin substitutes, or topical oxygen therapy). **A**

Table 20: International Working Group on Diabetic Foot risk stratification system and corresponding foot screening frequency

Category	Ulcer risk	Characteristics	Examination frequency*
0	Very low	No LOPS and no PAD	Annually
1	Low	LOPS or PAD	Every 6–12 months
2	Moderate	LOPS + **PAD, or** **LOPS** + foot deformity, or **PAD** + foot deformity	Every 3–6 months
3	High	LOPS or PAD and one or more of the following: • History of foot ulcer • Amputation (minor or major) • Kidney failure	Every 1–3 months

LOPS, loss of protective sensation; PAD, peripheral artery disease. *Examination frequency suggestions are based on expert opinion and person-centered requirements.

12. OLDER ADULTS: STANDARDS OF CARE IN DIABETES–2025

Diabetes Care 2026;49(Suppl. 1):S277–S296

Recommendations

- Assess the medical, psychological, functional (self-management abilities), and social domains in older adults with diabetes using a comprehensive approach to determine goals and therapeutic approaches for diabetes management. **B**
- Screen at least annually for geriatric syndromes (e.g., cognitive impairment, depression, urinary incontinence, falls, persistent pain, and frailty), hypoglycemia, and polypharmacy in older adults with diabetes, as they may affect diabetes management and diminish quality of life. **B**

NEUROCOGNITIVE FUNCTION

Recommendations

- Screening for early detection of mild cognitive impairment or dementia should be performed for adults 65 years of age or older at the initial visit, annually, and as appropriate. **B**

HYPOGLYCEMIA

Recommendations

- Ascertain and address episodes of hypoglycemia at routine visits because older adults with diabetes have a greater risk of hypoglycemia, especially when treated with hypoglycemic agents (e.g., sulfonylureas, meglitinides, and insulin). **B**
- Recommend continuous glucose monitoring (CGM) for older adults with type 1 diabetes **A** and type 2 diabetes on insulin therapy **B** to improve glycemic outcomes, reduce hypoglycemia, and reduce treatment burden.
- Consider the use of automated insulin delivery systems **B** and other advanced insulin delivery devices such as connected pens **E** to reduce risk of hypoglycemia for older adults, based on individual ability and support system.

TREATMENT GOALS

Recommendations

- Older adults with diabetes with few and stable coexisting chronic illnesses, and intact cognitive and functional status, should have lower glycemic goals (such as A1C <7.0–7.5% [<53–58 mmol/mol]) and/or time in range [TIR] 70–180 mg/dL [3.9–10.0 mmol/L] of ≥70% and time below range ≤70 mg/dL [≤3.9 mmol/L] of ≤4%) if CGM is used. **C**
- Older adults with diabetes and intermediate or complex health are clinically heterogeneous with variable life expectancy. Selection of glycemic goals should be individualized and should prioritize avoidance of hypoglycemia, with less stringent goals (such as A1C <8.0% [<64 mmol/mol] and/or TIR 70–180 mg/dL [3.9–10.0 mmol/L] of ≥50% and time below range <70 mg/dL [3.9 mmol/L] of <1%) for those with significant cognitive and/or functional limitations, frailty, severe comorbidities, and a less favorable risk-to-benefit ratio of diabetes medications. **C**
- Older adults with very complex or poor health receive minimal benefit from stringent glycemic goals. Clinicians should focus on avoiding hypoglycemia and symptomatic hyperglycemia. **C**
- Screening for diabetes complications should be individualized in older adults with diabetes. Prioritize screening for complications that would lead to impairment of functional status or quality of life. **C**
- The on-treatment blood pressure 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**
- Treatment of other cardiovascular risk factors should be individualized in older adults with diabetes, considering the time frame of benefit. Lipid-lowering therapy and antiplatelet agents may benefit those with life expectancies at least equal to the time frame of primary prevention or secondary intervention trials. **A**

LIFESTYLE MANAGEMENT

Recommendations

- 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**
- Recommend regular physical activity, including aerobic activity, weight-bearing exercise, and resistance training as tolerated in those who can safely engage in such activities, particularly to maintain lean body mass, especially in those pursuing weight loss. **B**
- For older adults with type 2 diabetes, overweight or obesity, and the capacity to exercise safely, an intensive lifestyle intervention focused on dietary changes, physical activity, and weight loss (e.g., 5–7%) should be considered for its benefits on quality of life, mobility and physical functioning, and cardiometabolic risk. **A**

PHARMACOLOGIC THERAPY

Recommendations

- Select medications with low risk of hypoglycemia in older adults with type 2 diabetes, specifically for those with hypoglycemia risk factors. **B**
- Deintensify hypoglycemiacausing medications (e.g., insulin, sulfonylureas, or meglitinides) or switch to a medication class with low hypoglycemia risk for individuals who are at high risk for hypoglycemia, using individualized glycemic goals. **B**
- In older adults with diabetes, deintensify diabetes medications for individuals for whom the harms and/or burdens of treatment may be greater than the benefits, within individualized glycemic goals. **E**
- Simplify complex treatment plans (especially insulin) to reduce the risk of hypoglycemia and polypharmacy and to decrease treatment burden. **B**
- In older adults with type 2 diabetes and established or high risk of atherosclerotic cardiovascular disease, heart failure, and/or chronic kidney disease, the treatment plan should include agents that reduce cardiovascular and kidney disease risk, irrespective of glycemia. **A**
- Consider costs of care and coverage when developing treatment plans to reduce risk of cost-related barriers to taking medication and performing self-management behaviors. **B**

TREATMENT IN POST-ACUTE AND LONG-TERM CARE SETTINGS

Recommendations

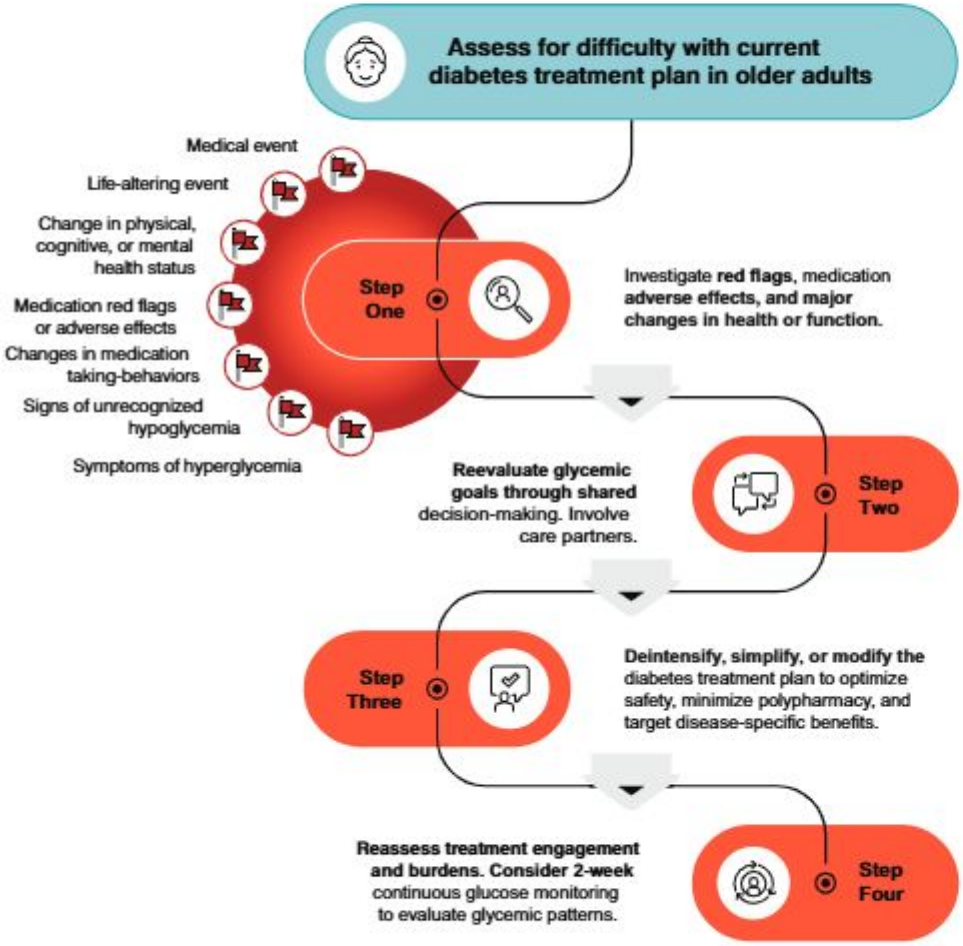
- Recommend diabetes education/training (including that for CGM devices, insulin pumps, and advanced insulin delivery systems) for the staff of post-acute and long-term care settings to improve the management of older adults with diabetes. **E**
- People with diabetes residing in post-acute and long-term care settings need careful assessment of mobility, mentation, medications, and management preferences to establish individualized glycemic goals and to make appropriate choices of glucoselowering agents and devices (including CGM devices, insulin pumps, and advanced insulin delivery systems) based on their clinical and functional status. **E**

END-OF-LIFE CARE

Recommendations

- When palliative care is needed in older adults with diabetes, health care professionals should discuss goals and intensity of care with people with diabetes and their care partners. Strict glucose, blood pressure, and lipid management are not necessary; consider deintensification or simplification of medication plans and prioritize symptom management. **E**
- Prioritize the overall comfort, prevention of distressing symptoms, and preservation of quality of life and dignity as primary goals for diabetes management at the end of life. **C**

Figure 16. Stepwise approach for assessing difficulties in the diabetes treatment plan; reevaluating glycemic goals through shared decisionmaking; deintensifying, simplifying, or modifying the treatment plan; and reassessing the safety and burdens of any interventions.



13. CHILDREN AND ADOLESCENTS: STANDARDS OF CARE IN DIABETES—2026

Diabetes Care 2026;49(Suppl. 1):S297–S320

GUIDELINES FOR ALL CHILDREN AND ADOLESCENTS WITH DIABETES

Diabetes Self-Management Education and Support

Recommendations

- Children and adolescents with diabetes, and their parents or caregivers (for individuals aged <18 years), should receive comprehensive, culturally sensitive, and developmentally appropriate individualized diabetes self-management education and support according to reference standards at diagnosis and routinely thereafter. **B**

Nutrition Therapy

Recommendations

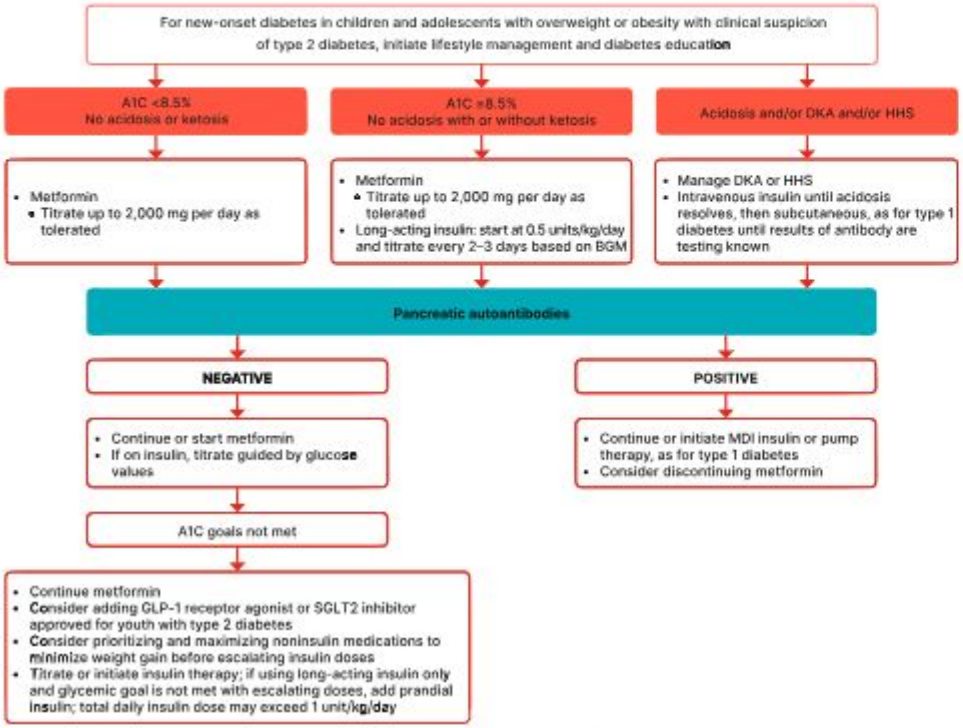
- Provide individualized medical nutrition therapy for children and adolescents with prediabetes or diabetes, emphasizing key nutrition principles (i.e., more nonstarchy vegetables, whole fruits, legumes, whole grains, nuts and seeds, and low-fat dairy products and less sugar-sweetened beverages, sweets, meat, refined grains, and processed or ultraprocessed foods), **B** as an essential component of the overall treatment plan.
- Monitor carbohydrate intake, whether by carbohydrate counting or experience-based estimation, as a key component to optimizing glycemic and weight management for children and adolescents with diabetes. **B**
- Educate children and adolescents and their caregivers on the potential need to adjust insulin with high-fat and high-protein meals. Meal composition affects postprandial glucose excursions. **A**
- In children and adolescents with diabetes, provide comprehensive nutrition education at diagnosis, and at least annually and ideally more frequently, by an experienced registered dietitian nutritionist to assess the eating pattern in relation to weight status, age-appropriate growth, risk for disordered eating behaviors, and cardiovascular disease risk factors. **E**

Physical Activity and Exercise

Recommendations

- Physical activity is recommended for all children and adolescents with diabetes with the goal of 60 min of moderate- to vigorous-intensity aerobic activity daily, with vigorous musclestrengthening and bone-strengthening activities at least 3 days per week. **B**
- Children and adolescents with diabetes using insulin therapy and their parents should monitor glucose levels before, during, and after physical activity and receive education about personalized glycemic goals according to the type and intensity of the planned physical activity. **C**
- Children and adolescents with diabetes and their parents or caregivers should be educated on strategies to prevent hypoglycemia during, after, and overnight following physical activity or exercise. Treatment for hypoglycemia should be accessible before, during, and after engaging in activity. **C**

Figure 17. Management of new-onset diabetes in youth with overweight or obesity with clinical suspicion of type 2 diabetes.



A1C 8.5% = 69 mmol/mol. BGM, blood glucose monitoring; CGM, continuous glucose monitoring; DKA, diabetic ketoacidosis; GLP-1, glucagon-like peptide 1; HHS, hyperosmolar hyperglycemic state; MDI, multiple daily injections; SGLT2, sodium–glucose cotransporter 2.

Psychosocial Care

Recommendations

- At diagnosis and during routine follow-up care, screen children and adolescents with type 1 diabetes, **B** type 2 diabetes, **B** and other forms of diabetes **E** for psychosocial concerns (e.g., diabetes distress, depressive symptoms, anxiety, disordered eating behaviors), family factors, and behavioral health concerns that could affect diabetes management with ageappropriate standardized and validated tools. Refer to a qualified behavioral health professional, preferably experienced in childhood diabetes, when indicated.
- Behavioral health professionals should be considered integral members of the pediatric diabetes interprofessional team. **E**
- Encourage developmentally appropriate family involvement in diabetes management tasks for children and adolescents with type 1 diabetes, type 2 diabetes, **B** and other forms of diabetes, **E** recognizing that premature or unsupportive transfer of diabetes care responsibility to children and adolescents can contribute to diabetes distress, lower engagement in diabetes self-management behaviors, and deterioration in glycemia.
- Health care professionals should screen for food insecurity, housing stability, health literacy, financial barriers, and social or community support and apply that information to treatment decisions. **E**

- Health care professionals should consider asking school-aged children and adolescents with type 1 diabetes, **B** type 2 diabetes, **E** and other forms of diabetes, **E** along with their parents or caregivers, about social adjustment (peer relationships) and school performance to determine whether further intervention is needed.
- Offer adolescents with diabetes time by themselves with their health care professional(s) at a developmentally appropriate age. **E**
- During adolescence, generally during the stage of pubertal growth and development, incorporate reproductive health and preconception counseling into routine diabetes clinic visits for all individuals of childbearing potential because of the risk of adverse pregnancy outcomes in this population. **A**

Glycemic Monitoring, Insulin Delivery, and Goals

Recommendations

- Continuous glucose monitoring (CGM) should be offered for diabetes management at diagnosis or as soon as possible in children and adolescents with diabetes who are capable of using the device safely (either by themselves or with caregivers). **A** The choice of device should be made based on the individual's and family's circumstances, desires, and needs.
- Offer automated insulin delivery (AID) systems for diabetes management to children and adolescents with type 1 diabetes who are capable of using the device safely (either by themselves or with caregivers). Choice of device should be made based on the individual's and family's circumstances, desires, and needs. **A**
- Offer open-loop insulin pump therapy for type 1 diabetes management to children and adolescents on multiple daily injections who are capable of using the device safely (either by themselves or with caregivers) if unable to use AID systems. Choice of device should be made based on the individual's and family's circumstances, desires, and needs. **A**
- Students with diabetes must be supported at school in the use of diabetes technology, including CGM, insulin pumps, connected insulin pens, and AID systems, as prescribed by their diabetes care team. **C**
- A1C goals must be individualized and reassessed over time. An A1C of <7% (<53 mmol/mol) is appropriate for most children and adolescents with diabetes. **B**
- Less stringent A1C goals (such as <7% [<53 mmol/mol] or <7.5% [<58 mmol/mol]) may be appropriate for children and adolescents with diabetes who cannot articulate symptoms of hypoglycemia; have hypoglycemia unawareness; cannot access advanced insulin delivery technology and/or CGM; cannot check blood glucose regularly; or have nonglycemic factors that increase A1C. **B**
- Even less stringent A1C goals may be appropriate for children and adolescents with diabetes and a history of severe hypoglycemia or limited life expectancy or where the harms of treatment are greater than the benefits. **B**
- Health care professionals may reasonably suggest more stringent A1C goals (such as <6.5% [<48 mmol/mol]) for selected children and adolescents with diabetes if they can be achieved without significant hypoglycemia, excessive weight gain, negative impacts on well-being or mental health, or undue burden of care or in those who have nonglycemic factors that decrease A1C (e.g., lower erythrocyte life span). Lower goals may also be appropriate during the honeymoon phase. **B**
- For children and adolescents with diabetes, CGM metrics derived from CGM use over the most recent 14 days (or longer) are recommended to be used in conjunction with or without A1C whenever possible. **B**

TYPE 2 DIABETES IN CHILDREN AND ADOLESCENTS

Screening and Diagnosis of Type 2 Diabetes in Children and Adolescents

Recommendations

- Consider risk-based screening for prediabetes and/or type 2 diabetes after the onset of puberty or after 10 years of age, whichever occurs earlier, in children with overweight (BMI ≥85th to <95th percentile) or obesity (BMI ≥95th percentile) and who have one or more additional risk factor for diabetes.
- If screening is normal, repeat screening at a minimum of 2-year intervals E or more frequently if BMI is increasing. **C**
- Fasting plasma glucose, 2-h plasma glucose during a 75-g oral glucose tolerance test, elevated random glucose with symptoms of hyperglycemia, and/or A1C can be used to test for prediabetes or type 2 diabetes in children and adolescents. **B**
- Children and adolescents with overweight or obesity with hyperglycemia in whom the diagnosis of type 2 diabetes is being considered should have a panel of pancreatic autoantibodies tested to exclude the possibility of autoimmune type 1 diabetes. **B**

Management

Lifestyle Management

Recommendations

- Provide children and adolescents with overweight or obesity and type 2 diabetes and their families with developmentally and culturally appropriate comprehensive lifestyle programs integrated with diabetes management to achieve at least a 7–10% decrease in excess weight. **B**
- Given the necessity of longterm weight management for children and adolescents with diabetes, lifestyle intervention should be based on a chronic care model and offered in the context of diabetes care. **E**

Glycemic Targets

Recommendations

- For children and adolescents with type 2 diabetes, glycemic status should be assessed at least every 3 months or as frequently as clinically indicated. **E**
- Consider setting an A1C goal of <6.5% (<48 mmol/mol) for most children and adolescents with type 2 diabetes who have a low risk of hypoglycemia. For those at higher risk of hypoglycemia, A1C goals should be individualized as clinically appropriate. **C**

Pharmacologic Management

Recommendations

- Initiate pharmacologic therapy with consideration of multiple add-on therapies early on, in addition to behavioral counseling for healthful nutrition and physical activity changes, at diagnosis of type 2 diabetes. **A**
- In individuals with incidentally diagnosed type 2 diabetes (A1C <8.5% [<69 mmol/mol] and asymptomatic), metformin is the initial pharmacologic treatment of choice unless contraindicated by kidney function. **A**
- Children and adolescents with marked hyperglycemia (A1C ≥8.5% [≥69 mmol/mol]) without acidosis at diagnosis should be treated initially with long-acting insulin while metformin is initiated and titrated. **B**

- Initiate subcutaneous or intravenous insulin treatment in individuals with ketoacidosis to rapidly correct the hyperglycemia and the metabolic derangement. Once acidosis is resolved, metformin should be initiated while subcutaneous insulin therapy is continued. **A**
- In individuals presenting with severe hyperglycemia (blood glucose ≥600 mg/dL [≥33.3 mmol/L]), consider assessment and treatment as needed for hyperglycemic hyperosmolar state. **A**
- If individualized glycemic goals are not achieved or maintained with metformin (with or without long-acting insulin), glucagon-like peptide 1 receptor agonist (GLP-1 RA) and/or sodium–glucose cotransporter 2 inhibitor (SGLT2i) should be considered in children and adolescents with type 2 diabetes of approved ages. **A**
- For children and adolescents with type 2 diabetes not meeting individualized glycemic goals, consider maximizing noninsulin therapies (metformin, GLP-1 RA, and SGLT2i) before initiating and/or intensifying the insulin therapy plan. **E**
- In individuals with type 2 diabetes initially treated with insulin and metformin and/or other glucoselowering medications who are meeting glucose goals based on blood glucose monitoring or CGM, reducing or discontinuing insulin should be considered. **B**

Metabolic Surgery

Recommendations

- Consider metabolic surgery for the treatment of adolescents with type 2 diabetes who have class 2 obesity or higher (BMI 35 to <40 kg/m^2 or 120% to <140% percentile for age and sex, whichever is lower) and who have elevated A1C and/or serious comorbidities despite lifestyle and pharmacologic intervention. **A**
- Metabolic surgery for adolescents with type 2 diabetes should be performed only by an experienced surgeon working as part of a wellorganized and engaged interprofessional team, including a surgeon, endocrinologist, registered dietitian nutritionist, behavioral health specialist, and nurse. **A**

SUBSTANCE USE AMONG ALL CHILDREN AND ADOLESCENTS WITH DIABETES

Tobacco, Electronic Cigarettes, Alcohol, and Cannabis

Recommendations

- Screen children and adolescents with diabetes for tobacco/nicotine vaping, substance use, and alcohol use at diagnosis and regularly thereafter, **C** discourage use and provide appropriate referrals to cessation programs as needed. **A**
- Advise all children, adolescents, and young adults with diabetes not to use cannabis recreationally in any form. **E**

TRANSITION FROM PEDIATRIC TO ADULT CARE FOR ALL CHILDREN AND ADOLESCENTS WITH DIABETES

Recommendations

- Diabetes care teams should implement transition preparation programs beginning in early adolescence and, at the latest, at least 1 year before the anticipated transfer from pediatric to adult health care. **E**
- Interprofessional adult and pediatric health care teams should provide support and resources for adolescents, young adults, and their families prior to and during the transfer process from pediatric to adult health care. **C**

- Pediatric diabetes specialists should partner with adolescents with diabetes and their caregivers to engage in shared decision-making for the timing of transfer to an adult diabetes specialist. There is no agespecific cutoff for young people with diabetes to transfer to an adult diabetes specialist. **E**

RECOMMENDATIONS FOR DIABETES-ASSOCIATED CONDITIONS IN CHILDREN AND ADOLESCENTS

Dyslipidemia

Type 1 diabetes recommendations

Recommendations

- For children and adolescents with type 1 diabetes, lipid screening should be performed soon after diagnosis, preferably after glycemia has improved and age is ≥2 years. If initial LDL cholesterol is ≤100 mg/dL (≤2.6 mmol/L), subsequent testing should be performed at 9–11 years of age **B** and repeated every 3 years. **E**

Type 2 diabetes recommendations

Recommendations

- In children and adolescents with type 2 diabetes, lipid screening should be performed soon after diagnosis, preferably after glycemia has improved and annually thereafter. **B**

Type 1 and 2 diabetes recommendations

Recommendations

- The LDL cholesterol goal is <100 mg/dL (<2.6 mmol/L). **E**
- In children and adolescents with diabetes, if lipids are abnormal, initial therapy should consist of optimizing glycemia and medical nutritional therapy to limit calories from fat to 25–30% and saturated fat to <7%, limit cholesterol to <200 mg/day, avoid trans fats, and aim for~10% calories from monounsaturated fats for elevated LDL. For elevated triglycerides, MNT should also focus on decreasing carbohydrate intake and increasing foods rich in n-3 fatty acids in addition to the above changes. **A**
- In children and adolescents with diabetes, if LDL cholesterol remains >130 mg/dL (>3.4 mmol/L) after 6 months of nutrition intervention, initiate therapy with a statin, with a goal of LDL <100 mg/dL (<2.6 mmol/L). Due to the potential teratogenic effects, individuals of childbearing potential should receive reproductive counseling, and statins should be avoided in individuals of childbearing potential who are not using reliable contraception. **B**
- In children and adolescents with diabetes, if triglycerides are >400 mg/dL (>4.7 mmol/L) fasting or >1,000 mg/dL (>11.6 mmol/L) nonfasting, optimize glycemia and begin fibrate, with a goal of <400 mg/dL (<4.7 mmol/L) fasting to reduce risk for pancreatitis. **C**

Hypertension

Type 1 and 2 diabetes recommendations

Recommendations

- In children and adolescents with diabetes, BP should be measured at every clinic visit. In children and adolescents with high BP (BP ≥90th percentile for age, sex, and height or, in adolescents aged ≥13 years, ≥120/80 mmHg) on three separate measurements, ambulatory BP monitoring should be strongly considered. **B**

- Excess weight increases cardiovascular event rates among people with diabetes and should be addressed with MNT, intensive lifestyle interventions focusing on dyslipidemia, hypertension, hyperglycemia along with adjunct pharmacotherapy, and/or bariatric surgery as appropriate. **C**
- In children and adolescents with diabetes, after excluding secondary hypertension, treatment of elevated BP (defined as 90th to <95th percentile for age, sex, and height or, in adolescents aged ≥13 years, 120–129/<80 mmHg) is lifestyle modification focused on healthy nutrition, physical activity, sleep, and, if appropriate, weight management. **C**
- For children and adolescents with diabetes, after excluding other causes, in addition to lifestyle modification, ACE inhibitors or ARBs should be started for treatment of confirmed hypertension (defined as BP consistently ≥ percentile for age, sex, and height or, in adolescents aged ≥13 years, BP ≥130/80 mmHg). Due to the potential teratogenic effects, individuals of childbearing potential should receive reproductive counseling, and ACE inhibitors and ARBs should be avoided in individuals of childbearing potential who are not using reliable contraception. **B**
- For children and adolescents the goal of hypertension treatment is BP <90th percentile for age, sex, and height or, in adolescents aged ≥13 years, BP <130/80 mmHg. **C**

Hypertension

Type 1 and 2 diabetes recommendations

Recommendations

- In children and adolescents with diabetes, BP should be measured at every clinic visit. In children and adolescents with high BP (BP ≥90th percentile for age, sex, and height or, in adolescents aged ≥13 years, ≥120/80 mmHg) on three separate measurements, ambulatory BP monitoring should be strongly considered. **B**
- Excess weight increases cardiovascular event rates among people with diabetes and should be addressed with MNT, intensive lifestyle interventions focusing on dyslipidemia, hypertension, hyperglycemia along with adjunct pharmacotherapy, and/or bariatric surgery as appropriate. **C**
- In children and adolescents with diabetes, after excluding secondary hypertension, treatment of elevated BP (defined as 90th to <95th percentile for age, sex, and height or, in adolescents aged ≥13 years, 120–129/<80 mmHg) is lifestyle modification focused on healthy nutrition, physical activity, sleep, and, if appropriate, weight management. **C**
- For children and adolescents with diabetes, after excluding other causes, in addition to lifestyle modification, ACE inhibitors or ARBs should be started for treatment of confirmed hypertension (defined as BP consistently ≥ percentile for age, sex, and height or, in adolescents aged ≥13 years, BP ≥130/80 mmHg). Due to the potential teratogenic effects, individuals of childbearing potential should receive reproductive counseling, and ACE inhibitors and ARBs should be avoided in individuals of childbearing potential who are not using reliable contraception. **B**
- For children and adolescents the goal of hypertension treatment is BP <90th percentile for age, sex, and height or, in adolescents aged ≥13 years, BP <130/80 mmHg. **C**

Nephropathy

Type 1 diabetes recommendations

Recommendations

- For children and adolescents with type 1 diabetes, nephropathy screening should be obtained at puberty or at age ≥11 years, whichever is earlier, once the youth have had diabetes for 5 years and annually thereafter. **B**

Type 2 diabetes recommendations

Recommendations

- In children and adolescents with type 2 diabetes, nephropathy screening should be performed at the time of diagnosis and annually thereafter. An elevated UACR (>30 mg/g creatinine) should be confirmed on two of three samples. **B**

Type 1 and 2 diabetes recommendations

Recommendations

- In children and adolescents with diabetes, nephropathy screening should be performed with a random spot urine sample. Consider obtaining a morning sample if there are effects of exercise or orthostatic changes. An elevated UACR (>30 mg/g creatinine) should be confirmed on two of three samples over a 6-month period. **B**
- Determine eGFR at the time of diagnosis and annually thereafter. **E**
- In nonpregnant children and adolescents with diabetes, either an ACE inhibitor or an ARB is recommended for those with moderately increased albuminuria (UACR 30–299 mg/g creatinine) B and is strongly recommended for those with severely increased albuminuria (UACR 2 ≥300 mg/g creatinine) and/or eGFR <60 mL/min/1.73 m^2 to maximally tolerated dose to prevent the progression of kidney disease and reduce cardiovascular events. A If one class is not tolerated, the other should be substituted. B Due to the potential teratogenic effects, individuals of childbearing potential should receive reproductive counseling, and ACE inhibitors and ARBs should be avoided in individuals of childbearing potential who are not using reliable contraception. **B**
- For children and adolescents with nephropathy, continue monitoring (every 3–6 months and/or as indicated by UACR and eGFR) to detect disease progression. **E**
- Refer to nephrology in case of uncertainty of etiology, worsening UACR, or decrease in eGFR. **E**

Retinopathy

Type 1 diabetes recommendations

Recommendations

- An initial dilated and comprehensive diabetes eye examination is recommended once youth have had type 1 diabetes for 3–5 years, provided they are aged ≥11 years or puberty has started, whichever is earlier. **B**
- For children and adolescents with type 1 diabetes, after the initial examination, repeat dilated and comprehensive eye examination or retinal photography is recommended every 2 years. Less frequent examinations, every 4 years, may be acceptable on the advice of an eye care professional and based on risk factor assessment, including a history of A1c < 8% (<64 mmol/mol). **B**

Type 2 diabetes recommendations

Recommendations

- Retinopathy screening in children and adolescents with type 2 diabetes should be performed at or soon after diagnosis and annually thereafter. **C**
- Less frequent examination (every 2 years) using dilated eye examination or retinal photography may be considered if achieving glycemic goals and a normal eye exam. **C**

Type 1 and 2 diabetes recommendations

Recommendations

- Optimizing glycemia is recommended to decrease the risk or slow the progression of retinopathy. **B**
- Programs that use nondilated retinal photography (with remote reading or use of a validated assessment tool) can be appropriate screening strategies for diabetic retinopathy. **B**

Neuropathy

Type 1 diabetes recommendations

- For children and adolescents with type 1 diabetes, consider an annual comprehensive foot exam at the start of puberty or at age ≥11 years, whichever is earlier, once the youth have had type 1 diabetes for 5 years. The examination should include inspection, assessment of foot pulses, pinprick, 10-g monofilament sensation tests, testing of vibration sensation using a 128-Hz tuning fork, and ankle reflex tests. **B**

Type 2 diabetes recommendations

- Screen children and adolescents with type 2 diabetes for the presence of neuropathy by foot examination at diagnosis and annually. The examination could include inspection, assessment of foot pulses, pinprick, 10-g monofilament sensation tests, testing of vibration sensation using a 128-Hz tuning fork, and ankle reflex tests. **C**

MASLD

Type 2 diabetes recommendations

- Evaluate children and adolescents with type 2 diabetes for MASLD (by measuring AST and ALT) at diagnosis and annually thereafter. **B**
- Consider referral to gastroenterology for persistently elevated or worsening transaminases. **B**

Obstructive sleep apnea

Type 1 and 2 diabetes recommendations

- In children and adolescents with diabetes, screening for symptoms of sleep apnea should be done at least annually, and referral to a pediatric sleep specialist is recommended for evaluation and a polysomnogram, if indicated. Obstructive sleep apnea should be treated when documented. **B**

Polycystic ovary syndrome

Type 1 and 2 diabetes recommendations

- Evaluate for polycystic ovary syndrome in adolescent girls with diabetes, including laboratory studies, when clinically indicated. **B**
- Metformin, in addition to lifestyle modification, is likely to improve the menstrual cyclicity and hyperandrogenism in adolescent girls with diabetes. **E**

Cardiovascular disease

Type 1 and 2 diabetes recommendations

- Excessive weight gain increases cardiovascular event rates among children and adolescents with diabetes and should be addressed with lifestyle and obesity pharmacotherapy as appropriate. **C**

Autoimmune conditions

Type 1 diabetes recommendations

- In children and adolescents with type 1 diabetes, assess for autoimmune conditions outside of critical illness if clinically indicated. **B**

Thyroid disease

Type 1 diabetes recommendations

- In children and adolescents with type 1 diabetes, measure thyroid-stimulating hormone concentrations at diagnosis when clinically stable or soon after optimizing glycemia. If normal, suggest rechecking every 1–2 years or sooner if the individual has positive thyroid antibodies or develops symptoms or signs suggestive of thyroid dysfunction, thyromegaly, an abnormal growth rate, or unexplained glycemic variability. **B**

Celiac disease

Type 1 diabetes recommendations

- Screen children and adolescents with type 1 diabetes outside of critical illness for celiac disease by measuring IgA tissue tTG antibodies, with documentation of acceptable serum IgA levels for the local assay, soon after the diagnosis of diabetes, or IgG tTG and deamidated gliadin antibodies if IgA is deficient. **B**
- Repeat screening for celiac disease within 2 years of type 1 diabetes diagnosis and then again after 5 years and consider more frequent screening in children and adolescents who have symptoms or a first-degree relative with celiac disease. **B**
- Prescribe a gluten-free eating pattern for children and adolescents with confirmed celiac disease to avoid nutritional complications. Refer children and adolescents and their caregivers to a registered dietitian nutritionist experienced in managing both diabetes and celiac disease. **B**

14. MANAGEMENT OF DIABETES IN PREGNANCY: STANDARDS OF CARE IN DIABETES–2026

Diabetes Care 2026;49(Suppl. 1):S321–S338

Preconception counseling

Recommendations

- Starting at puberty and continuing in all people with diabetes and childbearing potential, preconception counseling should be incorporated into routine diabetes care. **A**
- Family planning should be discussed, and effective contraception (with consideration of long-acting, reversible contraception) should be prescribed and used until an individual's treatment plan and A1C are optimized for pregnancy. **A**
- Preconception counseling should address the importance of achieving glucose levels as close to normal as is safely possible without excessive hypoglycemia, ideally A1C <6.5% (<48 mmol/mol), to reduce the risk of congenital anomalies, preeclampsia, macrosomia, preterm birth, and other complications. **A**
- Individuals with a history of gestational diabetes mellitus (GDM) should seek preconception screening for diabetes and preconception care to identify and treat hyperglycemia and prevent congenital malformations and other adverse maternal and fetal outcomes. **E**

Preconception counseling

Recommendations

- Starting at puberty and continuing in all people with diabetes and childbearing potential, preconception counseling should be incorporated into routine diabetes care. **A**
- Family planning should be discussed, and effective contraception (with consideration of long-acting, reversible contraception) should be prescribed and used until an individual's treatment plan and A1C are optimized for pregnancy. **A**
- Preconception counseling should address the importance of achieving glucose levels as close to normal as is safely possible without excessive hypoglycemia, ideally A1C <6.5% (<48 mmol/mol), to reduce the risk of congenital anomalies, preeclampsia, macrosomia, preterm birth, and other complications. **A**
- Individuals with a history of gestational diabetes mellitus (GDM) should seek preconception screening for diabetes and preconception care to identify and treat hyperglycemia and prevent congenital malformations and other adverse maternal and fetal outcomes. **E**

Preconception Care

Recommendations

- Individuals with preexisting diabetes who are planning a pregnancy should ideally begin receiving interprofessional care prior to conception, which includes an endocrinology health care professional, maternal-fetal medicine specialist, registered dietitian nutritionist, and diabetes care and education specialist, when available. **B**
- In addition to focused attention on achieving glycemic goals, A standard preconception care should be augmented with extra focus on nutrition, physical activity, diabetes self-care education, and screening for diabetes comorbidities and complications. **B**
- Individuals with preexisting diabetes who are planning a pregnancy or who have become pregnant should be counseled on the risk of development and/or progression of diabetic retinopathy. Dilated eye examinations should occur ideally before pregnancy as well as in the first

trimester, and then pregnant individuals should be monitored every trimester and for 1 year postpartum as indicated by the degree of retinopathy and as recommended by the eye care health care professional. **B**

GLYCEMIC GOALS IN PREGNANCY

Recommendations

- Fasting, preprandial, and postprandial blood glucose monitoring are recommended in individuals with diabetes in pregnancy to achieve optimal glucose levels. Glucose goals are fasting plasma glucose <95 mg/dL (<5.3 mmol/L) and either 1-h postprandial glucose <140 mg/dL (<7.8 mmol/L) or 2-h postprandial glucose <120 mg/dL (<6.7 mmol/L). **B**
- Due to increased red blood cell turnover, A1C is slightly lower during pregnancy in people with and without diabetes. Ideally, the A1C goal in pregnancy is <6% (<42 mmol/mol) if this can be achieved without significant hypoglycemia, but the goal may be relaxed to <7% (<53 mmol/mol) if necessary to prevent hypoglycemia. **B**
- Continuous glucose monitoring (CGM) can help to achieve glycemic goals (e.g., time in range, time above range) A and A1C goal B in type 1 diabetes and pregnancy and may be beneficial for other types of diabetes in pregnancy. **E**
- Recommend CGM to pregnant individuals with type 1 diabetes. A In conjunction with aims to achieve traditional pre- and postprandial glycemic goals, CGM can reduce the risk for large-for-gestational-age infants and neonatal hypoglycemia in pregnancy complicated by type 1 diabetes. **A**
- CGM metrics may be used in combination with blood glucose monitoring to achieve optimal pre- and postprandial glycemic goals. **E**
- Commonly used estimated A1C and glucose management indicator calculations should not be used in pregnancy as estimates of A1C. **C**

MANAGEMENT OF DIABETES IN PREGNANCY

Recommendations

- Nutrition counseling before and during pregnancy should promote an eating pattern including fruits, vegetables, legumes, whole grains, nuts, seeds, fish, and other lean protein, which will provide a balance of macronutrients and healthy n-3 fatty acids. **C**
- Lifestyle behavior change is an essential component of management of GDM and may suffice as treatment for many individuals. Insulin should be added if needed to achieve glycemic goals. **A**
- Telehealth visits used in combination with in-person visits for pregnant people with GDM can improve outcomes compared with standard in person care alone. **A**
- Insulin should be used to manage type 1 diabetes in pregnancy A and is the preferred agent for the management of GDM A and type 2 diabetes in pregnancy. **B**
- Either multiple daily injections or insulin pump technology can be used in pregnancy complicated by type 1 diabetes. **C**
- Automated insulin delivery (AID) systems with pregnancy-specific glucose targets are recommended for pregnant individuals with type 1 diabetes. **A**
- AID systems without pregnancyspecific glucose targets or a pregnancyspecific algorithm may be considered for select pregnant individuals with type 1 diabetes when used with assistive techniques and working with experienced health care teams. **B**

- Metformin and glyburide, individually or in combination, should not be used as first-line agents for management of diabetes in pregnancy, as both cross the placenta to the fetus **A** and may not be sufficient to achieve glycemic goals. **B** Other oral and noninsulin injectable glucose-lowering medications lack long-term safety data and are not recommended. **E**
- Metformin, when used to treat polycystic ovary syndrome and induce ovulation, should be discontinued by the end of the first trimester. **A**

PREECLAMPSIA AND ASPIRIN

Recommendations

- Pregnant individuals with type 1 or type 2 diabetes should be prescribed low-dose aspirin 100–150 mg/day starting at 12–16 weeks of gestation to lower the risk of preeclampsia. **E** A dosage of 162 mg/day may be acceptable; **E** currently, in the U.S., low-dose aspirin is available in 81-mg tablets.

PREGNANCY AND NON-GLUCOSE LOWERING DRUG CONSIDERATIONS

Recommendations

- In pregnant individuals with diabetes and chronic hypertension, a blood pressure threshold <140/90 mmHg is recommended for initiation and titration of therapy for better pregnancy outcomes. **A** Therapy should be deinensified if blood pressure is <90/60 mmHg. **E**
- Potentially harmful medications in pregnancy (e.g., ACE inhibitors, angiotensin receptor blockers, mineralocorticoid receptor antagonists) should be stopped prior to conception and avoided in sexually active individuals of childbearing potential who are not using reliable contraception. **B**
- In most circumstances, lipidlowering medications should be stopped prior to conception and avoided in sexually active individuals of childbearing potential with diabetes who are not using reliable contraception. **B** In some circumstances (familial hypercholesterolemia, severe hypertriglyceridemia, prior atherosclerotic cardiovascular disease event), lipidlowering therapy may be continued when the benefits outweigh risks. **E**

POSTPARTUM CARE

Recommendations

- Insulin requirements need to be evaluated and adjusted for individuals requiring insulin after delivery because insulin resistance decreases dramatically immediately postpartum. **C**
- A contraceptive plan should be discussed and implemented with all people with diabetes of childbearing potential. **A**
- Breastfeeding efforts are recommended for all individuals with diabetes. **A** Breastfeeding is recommended for individuals with a history of GDM for multiple benefits, A including a reduced risk for type 2 diabetes later in life. **B**
- Postpartum care should include psychosocial assessment and support for self-care. **E**
- Screen individuals with a recent history of GDM at 4–12 weeks postpartum, using the 75-g oral glucose tolerance test and clinically appropriate nonpregnancy diagnostic criteria. **B**
- Individuals with a history of GDM should have lifelong screening for the development of type 2 diabetes or prediabetes every 1–3 years. **B**
- Individuals with overweight or obesity and a history of GDM found to have prediabetes should receive intensive lifestyle interventions and/or metformin to prevent diabetes. **A**

15. DIABETES CARE IN THE HOSPITAL: STANDARDS OF CARE IN DIABETES–2026

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HOSPITAL CARE DELIVERY STANDARDS

Recommendations

- Perform an A1C test on all people with diabetes or hyperglycemia (random blood glucose >140 mg/dL [>7.8 mmol/L]) at the time of admission to the hospital if no A1C test result is available from the prior 3 months. **B**
- Institutions should implement protocols using validated written or computerized provider order entry sets for management of dysglycemia in the hospital that allow for a personalized approach. **B**

Diabetes Care Specialist in the Hospital

Recommendations

- When caring for hospitalized people with diabetes (with an existing or new diagnosis) or stress hyperglycemia, consult with a specialized diabetes or glucose management team when available. **B**

GLYCEMIC GOALS IN HOSPITALIZED ADULTS

Recommendations

- Insulin should be initiated or intensified for treatment of persistent hyperglycemia starting at a threshold of ≥180 mg/dL (≥10.0 mmol/L) (confirmed on two occasions within 24 h) for the majority of critically ill individuals (those in the intensive care unit [ICU]). **A**
- Insulin and/or other glucose lowering therapies should be initiated or intensified for treatment of persistent hyperglycemia starting at a threshold of ≥180 mg/dL (≥10.0 mmol/L) (confirmed on two occasions within 24 h) for the majority of noncritically ill individuals (those not in the ICU). **B**
- Once therapy is initiated, a glycemic goal of 140–180 mg/dL (7.8–10.0 mmol/L) is recommended for most critically ill individuals (those in the ICU) with hyperglycemia. **A**
- More stringent individualized glycemic goals may be appropriate for selected critically ill individuals if they can be achieved without significant hypoglycemia. **B**
- For noncritically ill individuals (those not in the ICU), a glycemic goal of 100–180 mg/dL (5.6–10.0 mmol/L) is recommended if it can be achieved without significant hypoglycemia. **B**

Continuous Glucose Monitoring

Recommendations

- In people with diabetes using a personal continuous glucose monitoring (CGM) device, the use of CGM should be continued during hospitalization if clinically appropriate, with confirmatory point-of-care (POC) blood glucose measurements for insulin dosing decisions and hypoglycemia assessment, if resources and training are available, and according to an institutional protocol. **B**

GLUCOSE-LOWERING TREATMENT IN HOSPITALIZED INDIVIDUALS

Insulin Therapy

Recommendations

- Continuous intravenous insulin infusion is recommended for achieving glycemic goals and avoiding hypoglycemia in critically ill individuals. **A**
- Basal insulin or a basal plus correction insulin plan is the preferred treatment for noncritically ill hospitalized individuals with poor or no oral intake. **A**
- An insulin plan with basal, prandial, and correction components is the preferred treatment for most noncritically ill hospitalized individuals with adequate nutritional intake. **A**
- For most individuals, sole use of a correction or supplemental insulin without basal insulin (formerly referred to as a sliding scale) in the inpatient setting is discouraged. **A**

Noninsulin Therapies

Recommendations

- It is recommended that use of a sodium–glucose cotransporter 2 inhibitor be initiated or continued during hospitalization if indicated for heart failure, providing there are no contraindications. **A**

HYPOGLYCEMIA

Recommendations

- A hypoglycemia management protocol should be adopted by all health systems. **A** plan for identifying, treating, and preventing hypoglycemia should be established for each individual. Episodes of hypoglycemia in the hospital should be documented in the health record and tracked to inform quality improvements. **C**
- Treatment plans should be reviewed and changed as necessary to prevent hypoglycemia and recurrent hypoglycemia when a blood glucose value of <70 mg/dL (<3.9 mmol/L) is documented. **C**

TRANSITION FROM THE HOSPITAL TO THE AMBULATORY SETTING

Recommendations

- A structured discharge plan should be tailored to the individual with diabetes. **B** For those not being discharged to home, consider the capabilities of the facility for diabetes management. **E**