Standards of Care in Diabetes 2026

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BEFORE WE START

Objectives, and how to read the evidence

1. Identify the 2026 changes most likely to alter everyday practice
2. Apply the new technology and obesity recommendations across diabetes types
3. Choose glucose-lowering therapy by heart, kidney, and liver benefit

Recommendation numbers point to the exact wording in the 2026 Standards. **NEW** marks content new or revised for 2026.

Evidence grades

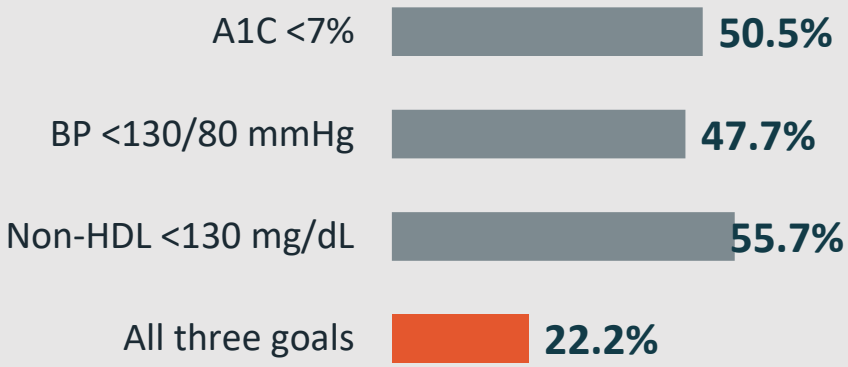
A	Well-conducted, generalizable RCTs or quality-rated meta-analyses
B	RCTs with a limiting flaw, or well-conducted cohort or case-control studies
C	Poorly controlled or uncontrolled studies, or conflicting evidence
E	Expert consensus or clinical experience

ADA Professional Practice Committee; full revision each December, with online updates between editions

Only 22% reach all three goals: talk about cost and social needs

US adults with diabetes at each goal

NHANES 2015 to 2018, cited in Section 1



Many who missed a goal were untreated or undertreated for that risk factor

Discuss cost in every treatment decision

NEW Shared decisions now include informed financial considerations Rec 1.1

In 2021, **18.6%** with type 1 and **15.8%** with insulin-treated type 2 reported cost-related barriers to taking medicines

Ask about social needs at visits

Unchanged but central ***Rec 1.7***

- **Food insecurity**
- **Housing**
- **Financial barriers**
- **Access to care**

Let the answers shape the plan; refer to community resources

SECTION 2 · DIAGNOSIS AND CLASSIFICATION

Diagnostic thresholds did not change

≥6.5%	≥126	≥200	≥200
A1C	**Fasting plasma glucose, mg/dL**	**2-h glucose, 75-g OGTT, mg/dL**	**Random glucose, mg/dL, with symptoms or crisis**

Confirm before labeling

- Without unequivocal hyperglycemia, confirm with a second abnormal result Rec 2.1b
- Two different tests from the same sample can confirm
- Investigate glucose and A1C discordance Rec 2.3

When A1C misleads

- Hemoglobin variants, pregnancy, G6PD deficiency, HIV, altered red cell turnover: use glucose criteria Rec 2.4
- Point-of-care A1C for diagnosis only on FDA-cleared devices in moderate-complexity CLIA labs Rec 2.2b

Who to screen

- All adults from age 35 Rec 2.12b
- Any age: overweight or obesity plus a risk factor Rec 2.12a
- Repeat at least every 3 years if normal Rec 2.12c
- Second-generation antipsychotics: baseline, 12 to 16 weeks, then yearly Rec 2.16b

SECTION 2 · PRESYMPTOMATIC TYPE 1 DIABETES

Type 1 screening before diabetes: what each result means

Screen relatives and others at genetic risk for insulin, GAD, IA-2, and ZnT8 antibodies **Recs 2.6, 2.7; confirm a first positive within 3 months**

Any positive
1 or more antibodies

Check now for diabetes (stage 3)
A1C, urinalysis, or plasma glucose Rec 2.8a

2 or more
or IA-2 alone (NEW)

Refer for staging and monitor
A1C about every 6 months, OGTT yearly
Recs 2.8b, 2.9, 3.2

Other single
GAD, insulin, or ZnT8

Repeat antibodies
Not stage 1 (that needs 2 or more); retest every 6 months to 3 years, by age Rec 2.9

Already has diabetes? Then one positive antibody is enough to call it type 1 (next slide)

1 **Stage 1 · presymptomatic**

2 or more antibodies, normal glucose; 5-year risk of stage 3 about 44%

2 **Stage 2 · presymptomatic**

Antibodies plus dysglycemia: FPG 100 to 125, 2-h 140 to 199, or A1C 5.7 to 6.4%; stage 3 in about 60% by 2 years, 75% by 5

Teplizumab from age 8: stage 3 delayed about 2 years (TN-10: 48.4 vs 24.4 months, HR 0.41) Rec 3.17

3 **Stage 3 · symptomatic**

Diabetes by standard criteria; antibodies may disappear

SECTION 2 · CLASSIFICATION IN ADULTS (FIGURE 2.1)

Adults with suspected type 1: antibodies first, C-peptide later

Adult who already has diabetes: could it be type 1? Rec 2.10

AABBCC: Age <35 · Autoimmunity · BMI <25 · Family history of type 1 · Not at goal without insulin · Checkpoint inhibitors

↓

Step 1: islet antibodies GAD first, then IA-2 and/or ZnT8 → **Positive: type 1** one antibody is enough

Negative:

Under 35, no type 2 or MODY features

Still type 1: 5 to 10% of type 1 has no antibodies

Under 35 with MODY features

Check C-peptide now: >0.6 ng/mL, test for MODY; <0.6, type 1

35 or older, or type 2 features

Unclear: treat clinically. On insulin for more than 3 years? Go to step 2

Step 2: C-peptide, on insulin for more than 3 years (ng/mL)

<0.6 Type 1	**0.6 to 1.8** Indeterminate: repeat after 5+ years	**≥1.8** Type 2

Same cutoffs in pmol/L: 200 and 600

Why wait 3 years?

- Adults with new type 1 often keep making insulin for months to years, so an early normal value does not rule it out
- High glucose and DKA suppress insulin release, so early values can look falsely low

Why only on insulin?

It answers one question: can this person safely cut back or stop insulin? Check it before stopping.

Drawing it

- Random sample within 5 h of a meal, with glucose
- <1.8 with glucose <70 or fasting: repeat
- Not within 2 weeks of DKA or HHS

SECTIONS 2, 3, AND 9 · NEW

Steroids and cancer drugs now come with a glucose plan

Therapy	Monitor (Section 2)	Prevent (Section 3)	Treat (Section 9)
Glucocorticoids recurrent, long-term, or high dose	Postprandial or random glucose Rec 2.18	Metformin if high risk on high-dose steroids Rec 3.9	Match therapy to the steroid schedule; reassess often Rec 9.36
Checkpoint inhibitors PD-1: nivolumab, pembrolizumab PD-L1: durvalumab, avelumab Less often CTLA-4: ipilimumab	Counsel; glucose before starting, at each visit, with symptoms, and after stopping Recs 2.19, 2.20	*No specific recommendation* Occurs in 0.6 to 1.4%, often as DKA; peaks at 2 to 3 months, but can follow stopping	Assess at once for insulin need (DKA risk); test for immunotherapy-associated diabetes Rec 9.33
PI3K-alpha inhibitors alpelisib, inavolisib Grade 3 to 4 in up to 36%; median onset 13 days	Glucose and A1C at baseline; random glucose weekly for 2 weeks, then every 4 weeks; A1C every 3 months Rec 2.21	Metformin if high risk: age ≥70, BMI ≥30, on steroids, or A1C ≥5.7% Rec 3.8	Metformin first, then pioglitazone or SGLT2 inhibitor; insulin or sulfonylurea last; no GLP-1 RA for now Recs 9.35a, 9.35b
mTOR inhibitors everolimus	Glucose before starting and at each visit; A1C every 3 months Rec 2.22	*No specific recommendation*	Metformin first line Rec 9.34

Transplant: insulin right after surgery, or a DPP-4 inhibitor if mild Rec 9.37; long term, noninsulin drugs, and a GLP-1 RA can be considered for heart, kidney, weight, and liver benefit; add insulin if not at goal
Recs 9.38a to 9.38c

SECTION 3 · PREVENTION OR DELAY

Prevention in prediabetes: a stepped plan

1 — Find and follow

- Prediabetes: A1C 5.7 to 6.4%, FPG 100 to 125, or 2-h 140 to 199 mg/dL
- Test yearly for progression to any type of diabetes Rec 3.1

→

2 — Refer to a program

- Overweight or obesity at high risk: prevention program Rec 3.3
- Goal: at least 5 to 7% weight loss and 150 min/week
- Certified apps, web, or telehealth count Rec 3.6

→

3 — Prescribe an eating pattern NEW

- Mediterranean or low-carbohydrate Rec 3.4
- Details on the next slide

→

4 — Add metformin

- Highest risk: age 25 to 59 with BMI ≥35, FPG ≥110, A1C ≥6.0%, or prior GDM Rec 3.7
- Check B12 on long-term use Rec 3.10

→

5 — Treat the whole risk

- Treat CV risk factors; keep statins Recs 3.11, 3.12
- Weight-loss medicines when they fit goals Rec 3.15

6 — Lifestyle program vs placebo (DPP trial)

58% fewer new cases over 3 years; still 24% fewer at 21 years

7 — Metformin vs placebo (DPP trial)

50% fewer cases after gestational diabetes, as with lifestyle; overall less effective than lifestyle, except with BMI ≥35 or age 25 to 44

SECTION 3 · PREVENTION · NEW

Prescribe an eating pattern: Mediterranean or low-carbohydrate

Rx Evidence-based eating pattern — NEW · Rec 3.4 · grade B

FOR	People with prediabetes
PATTERN	Mediterranean or low-carbohydrate, chosen with the patient
DOSE	Reduced-calorie, for at least 5 to 7% weight loss, plus 150 min/week of activity Rec 3.3
THROUGH	A diabetes prevention program or dietitian; certified apps and telehealth count Recs 3.5, 3.6
FOLLOW-UP	Reassess at each visit; the pattern the patient keeps beats the ideal one
CAUTION	Avoid very-low-carb (ketogenic) plans with SGLT2 inhibitors, and in pregnancy, kidney disease, or disordered eating

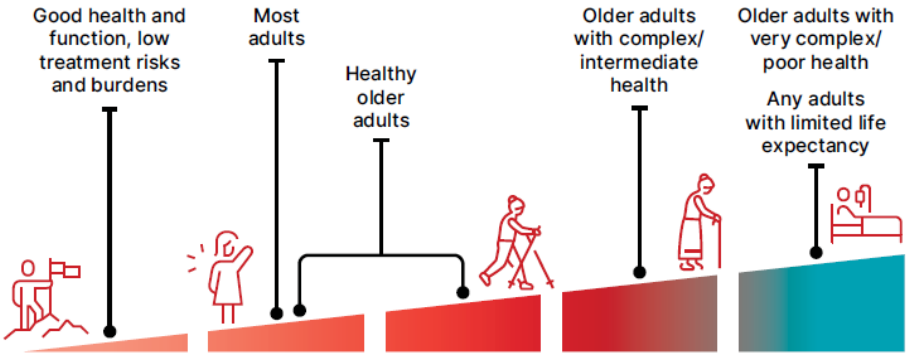
Mediterranean

- Vegetables, whole grains, legumes, nuts, olive oil; fish over red meat
- Highest adherence: 13% lower diabetes risk
- Lowers CV risk (grade A) Rec 5.30

Low-carbohydrate

- Carbohydrate under 26% of energy, about 130 g/day
- Larger A1C drop by 6 months; similar after 1 year
- Not ketogenic: no added A1C benefit, and LDL rises

6. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises



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

Figure 6.1
Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S132-S149

American Diabetes Association.

SECTION 6 · HYPOGLYCEMIA AND CRISES

Prevent lows and crises before they reach the hospital

Hypoglycemia levels (Table 6.4)

Level 1	<70 and ≥54 mg/dL
Level 2	<54 mg/dL
Level 3	Severe event needing assistance

Any level 2 or 3 event: reevaluate the plan, deintensify or switch Rec 6.19

Treat and be ready

- Glucose preferred; recheck at 15 minutes Rec 6.15
- Glucagon for everyone on insulin or at high risk; ready-to-use forms preferred Rec 6.16
- **NEW** First aid kits should include oral glucose Rec 6.17

Prevent hyperglycemic crises

- Review DKA and HHS history at every visit for those at risk Rec 6.21
- Structured prevention education for type 1 and others at risk Rec 6.22; sick-day guidance names drugs to hold

CGM from diagnosis for anyone it helps

Rec 7.15: CGM at onset and anytime after, for children, adolescents, and adults — Letters are evidence grades

A	On insulin
C	On noninsulin drugs that can cause hypoglycemia
C	On any treatment where CGM helps management

Make it work

- On insulin, wear it as close to daily as possible Rec 7.16
- A meter on hand at all times Rec 7.10
- **NEW** Real-time, over-the-counter, and professional CGM; intermittently scanned no longer listed Table 7.3
- Review medicines and supplements for interference

Interfering substances: all read falsely high Table 7.4

Acetaminophen >4 g/day	Dexcom G6, G7
Acetaminophen, any dose	Medtronic Guardian 4
Vitamin C >500 mg/day	FreeStyle Libre 2, 3
Vitamin C >1,000 mg/day	FreeStyle Libre 2 Plus, 3 Plus
Hydroxyurea	Dexcom G6, G7; Medtronic Guardian 4
Mannitol or sorbitol, IV or in peritoneal dialysis solution	Senseonics Eversense 365

AID is the preferred way to deliver insulin

Preferred over injections, standard pumps, and sensor-augmented pumps

- Type 1 diabetes
- Type 2 diabetes on multiple daily injections or a pump
- Other insulin-deficient diabetes

Rec 7.25a · grade A

Widen the door

- Consider for type 2 on basal insulin not at goal Rec 7.25b
- Offer to all adults on insulin Rec 9.27
- No C-peptide, antibody, or insulin-duration requirement Rec 7.8a

Support use

- **NEW** Device support at school; reasonable accommodations at work Recs 7.6, 7.7
- Separate education for CGM and AID Recs 7.3a, 7.3b
- Continue personal devices in hospital under protocol Recs 7.29, 7.30

SECTION 5 · HEALTH BEHAVIORS AND WELL-BEING

A yearly behavioral screen, now with anxiety and fear of lows

Diabetes distress

Yearly, caregivers too; refer if unresolved

Rec 5.45

Depression

Yearly and when complications appear

Recs 5.48, 5.49

NEW

Anxiety symptoms

Yearly for everyone

Rec 5.46

NEW

Fear of hypoglycemia

High risk, or severe or frequent lows

Rec 5.47

Disordered eating

Validated screen; review drug effects on hunger

Rec 5.50

NEW

Sleep health

With, or at risk for, diabetes

Rec 5.56

Also in Section 5

- Ask routinely about tobacco and vaping; advise avoiding both Rec 5.40
- Avoid recreational cannabis with DKA risk Rec 5.41
- Motivational interviewing and goal setting in DSMES Rec 5.4
- Protect protein and micronutrients during weight loss Rec 5.23
- Activity: 150 min/week over 3 or more days; resistance 2 to 3 times a week Recs 5.36, 5.37
- Religious fasting: updated IDF-DAR prefasting risk score Table 5.3

SECTION 8 · OBESITY AND WEIGHT MANAGEMENT

Weight is a primary treatment goal, not an afterthought

Assess

- **NEW** BMI yearly, confirmed with waist-to-hip ratio, DXA, or bioimpedance where available Rec 8.2a
- Every 3 months during active treatment Rec 8.2b

Set the goal

- 5 to 7% loss improves glycemia and risk factors Rec 8.5
- Sustained loss above 10% can modify disease and allow remission

Intensive lifestyle program

- At least 16 counseling sessions in 6 months, aiming for a 500 to 750 kcal/day deficit Rec 8.8a
- Then monthly contact for at least a year to keep weight off Rec 8.11

Medicines and surgery

- Semaglutide or tirzepatide preferred Rec 8.18
- **NEW** Best dose may be below the maximum approved dose Rec 8.20
- Consider surgery from BMI 30 (27.5 if Asian American) Rec 8.22

SECTIONS 8 AND 9 · IN PRACTICE

Starting GLP-1-based therapy: dose to tolerance, check safety

Dose to tolerance

- **NEW** Smaller steps, slower titration; the best dose may be below the maximum Rec 8.20
- Each visit: side effects, weight change, appetite; escalate if tolerated, hold if not, switch if intolerable
- Check that people still eat enough protein; add resistance training Recs 5.23, 5.39
- Reduce sulfonylureas and insulin at the start to prevent lows Recs 9.17, 9.22

Check before and during

- GI effects, gallbladder disease, prior pancreatitis
- Rapid A1C lowering can worsen retinopathy: baseline eye exam if present
- NAION is a very rare risk (EMA): discuss it; sudden vision loss needs urgent eye review
- Contraindicated with medullary thyroid cancer or MEN2, personal or family history
- Tirzepatide lowers oral contraceptive levels: barrier method for 4 weeks after starting and each dose increase
- Stop before a planned pregnancy (Section 15)

Since publication: oral semaglutide 25 mg (Wegovy pill, December 2025) and oral orforglipron (Foundayo, April 2026) were FDA-approved for chronic weight management

SECTION 8 · NEW

Obesity in type 1 diabetes is now treated, too

Rec 8.29

Adults with type 1 diabetes and BMI ≥30 (≥27.5 in Asian American individuals)

GLP-1 RA-based therapy	grade B
Metabolic surgery	grade C

With shared decision-making

Favors treatment

- Obstructive sleep apnea
- MASH
- Coronary disease

Argues against starting

- Gastroparesis
- Hypoglycemia unawareness
- Recent DKA or euglycemic ketoacidosis

Four cautions in practice

1. Cut basal and bolus doses early as intake falls
2. Titrate more slowly than in type 2
3. Keep carbohydrate adequate; teach ketone checks
4. Plan for stopping: insulin needs rise again

SECTION 9 · PHARMACOLOGIC TREATMENT

Choose by organ first, glycemia second

Irrespective of A1C: protect the organ at risk · "A1C" is now "glycemia" because CGM metrics count

ASCVD or high risk

- GLP-1 RA: dulaglutide, liraglutide, or semaglutide, injectable or oral Rec 9.7
- And/or SGLT2 inhibitor: canagliflozin or empagliflozin

Heart failure

- SGLT2 inhibitor for HFrEF or HFpEF: dapagliflozin or empagliflozin Rec 9.8
- **NEW** Obesity with symptomatic HFpEF: tirzepatide or semaglutide Recs 9.9a, 9.9b

Chronic kidney disease

- eGFR 20 to 60 and/or albuminuria: canagliflozin, dapagliflozin, or empagliflozin, or semaglutide Rec 9.10
- eGFR <30: a GLP-1 RA is preferred, even on dialysis; not exenatide or lixisenatide Rec 9.11

MASLD or MASH

- **NEW** MASH or high fibrosis risk: semaglutide preferred (grade A) Rec 9.13a
- Pioglitazone, tirzepatide, or pioglitazone plus a GLP-1 RA can be considered (grade B) Recs 9.13a, 9.13b

Since publication: tirzepatide FDA-approved to lower MACE in type 2 diabetes (August 2026; noninferior to dulaglutide in SURPASS-CVOT). ADA/EASD 2026 consensus (October 2026): SGLT2 inhibitor and/or GLP-1-based therapy early, potentially from diagnosis, independent of metformin

Then glycemia and weight: combination therapy at the start Rec 9.6; no DPP-4 inhibitor with GLP-1-based drugs Rec 9.18
Insulin first only for severe hyperglycemia Rec 9.20; otherwise GLP-1-based therapy first, paired with any insulin Recs 9.21, 9.22

9. Pharmacologic Approaches to Glycemic Treatment

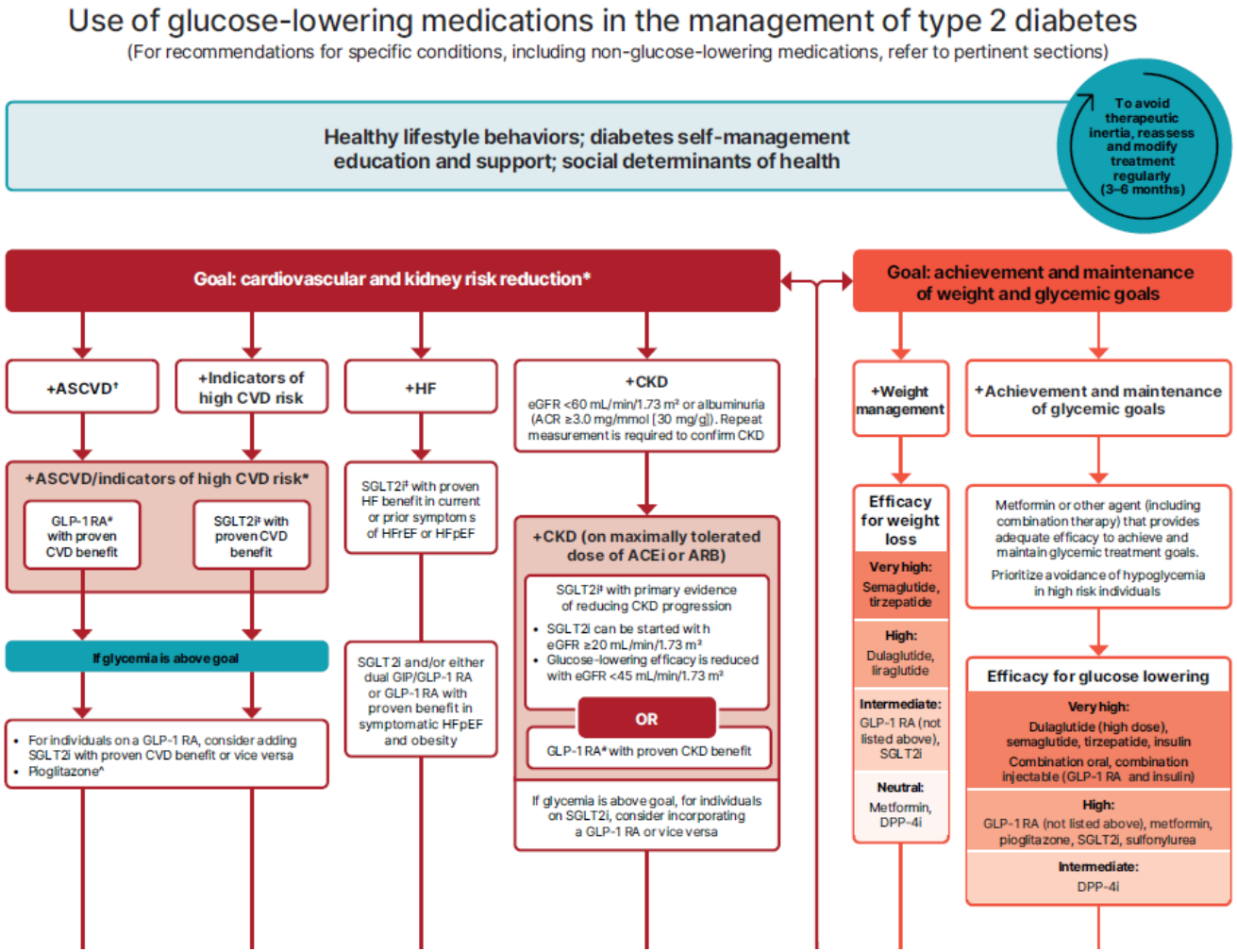
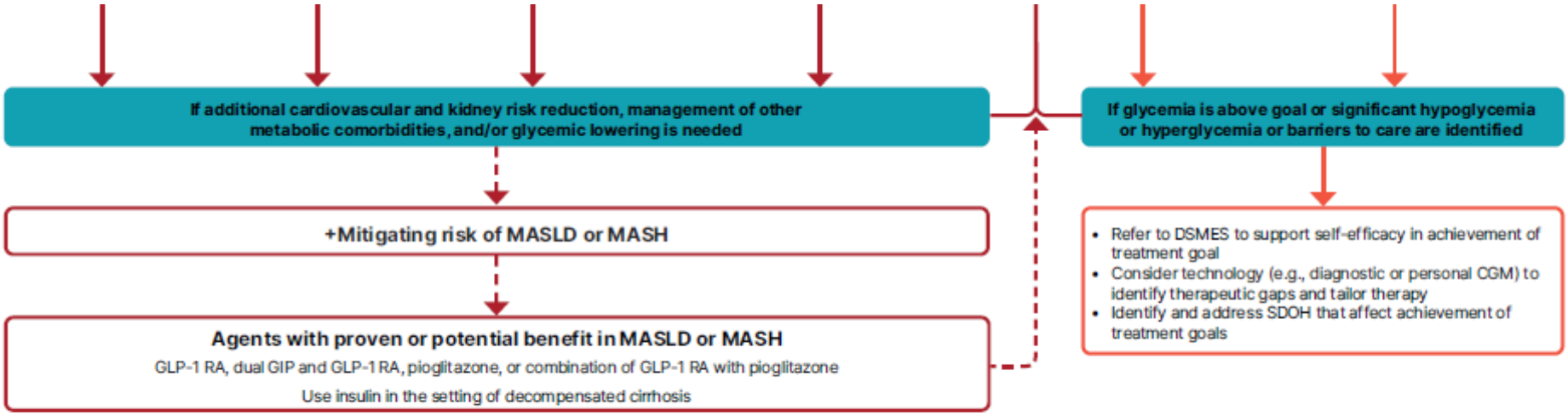


Figure 9.4
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

American Diabetes Association.

9. Pharmacologic Approaches to Glycemic Treatment



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

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

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

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

‡ For SGLT2is, CV and kidney outcomes trials demonstrate their efficacy in reducing the risks of composite MACE, CV death, all-cause mortality, MI, 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.

Figure 9.4 (continued)
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

American Diabetes Association.

SECTION 9 · INSULIN IN TYPE 2 DIABETES

Insulin when needed, but GLP-1-based therapy comes first

1 Start insulin now if

- Catabolic symptoms, A1C >10%, or glucose ≥300 mg/dL, whatever the background therapy Rec 9.20

→

2 Otherwise, incretin first

- GLP-1 RA or GIP/GLP-1 RA preferred over insulin for initial or add-on therapy Rec 9.21

→

3 If insulin, pair it

- Combine with a GLP-1 RA or GIP/GLP-1 RA; recheck insulin doses as the incretin is titrated Rec 9.22
- Keep agents with metabolic benefit Rec 9.23

→

4 Keep it safe

- Watch for overbasalization Rec 9.26
- CGM at insulin start Rec 9.25
- Offer AID Rec 9.27
- Reassess sulfonylureas and meglitinides when adding agents Rec 9.17

Since publication: weekly basal insulins for type 2 diabetes: icodec (Awiqli; adults March 2026, children 10 and older October 2026) and efsitora (Onswik; adults, September 2026); neither is approved for type 1

Cost is a clinical variable: screen for financial barriers Rec 9.29; lower-cost options include metformin, sulfonylureas, TZDs, and human insulin Rec 9.30; avoid compounded, non-FDA-approved products Rec 9.31a

American Diabetes Association.

A systolic goal below 120 mmHg for high-risk patients

<120

mmHg systolic

Encouraged at high cardiovascular or kidney risk, when it can be safely attained

Rec 10.4 · grade A. <130/80 remains the goal for most

≥120/80	Lifestyle therapy Rec 10.5
≥130/80	Start medication and titrate to goal; hypertension = 130/80 or higher on two occasions Recs 10.1, 10.6
≥150/90	Two drugs or a single-pill combination Rec 10.7
Resistant	Add an MRA after three classes, including a diuretic Rec 10.13

Albuminuria or CAD: ACE inhibitor or ARB first, never together Recs 10.8 to 10.10 · home BP for everyone with hypertension Rec 10.2

SECTION 10 · LIPIDS, ANTITHROMBOTICS, AND PAD

Lipids: same LDL goals, no add-ons without CV benefit

LDL GOALS · UNCHANGED

<70 mg/dL LDL	**Age 40 to 75 with risk factors** High-intensity statin, LDL at least 50% lower Rec 10.20; consider ezetimibe or a PCSK9 inhibitor if still ≥70 Rec 10.21
<55 mg/dL LDL	**Established ASCVD** High-intensity statin, LDL at least 50% lower; add ezetimibe or a PCSK9 inhibitor if not at goal Rec 10.27

NEW **Stop the add-ons:** no fibrate, niacin, or omega-3 supplement on top of a statin; none lowers CV risk further Rec 10.32, grade A

Still useful: icosapent ethyl for TG 150 to 499 mg/dL with ASCVD or risk factors Rec 10.31; fibrate or fish oil for TG ≥500 to lower pancreatitis risk Rec 10.29

Antithrombotics, PAD, cardiorenal

- Stable CAD or PAD, low bleeding risk: aspirin 81 mg plus rivaroxaban 2.5 mg twice daily Rec 10.35
- Primary prevention aspirin only after a bleeding-risk discussion Rec 10.36
- ABI from age 65, or with microvascular disease or foot complications Rec 10.39; semaglutide improved walking distance in PAD (STRIDE)
- **NEW** CKD is now an indication for a GLP-1 RA with CV benefit: dulaglutide, liraglutide, or semaglutide Rec 10.40c

Look for heart failure before symptoms start

Consider screening adults with diabetes with BNP or NT-proBNP Rec 10.38a · grade B

Abnormal (BNP ≥50 or NT-proBNP ≥125 pg/mL): echocardiogram to look for stage B Rec 10.38b · grade A

Kidney disease, pulmonary hypertension, COPD, sleep apnea, stroke, and anemia raise levels; obesity lowers them

A **Stage A: At risk** Diabetes alone qualifies → B **Stage B: Pre-heart failure** No symptoms, but abnormal heart or high BNP → C **Stage C: Symptomatic** Current or past heart failure symptoms → D **Stage D: Advanced** Symptoms despite full therapy

Stage B: prevent symptoms

- Guideline-directed therapy with cardiology Rec 10.44a
- ACE inhibitor or ARB plus beta-blocker Rec 10.44b
- **NEW** Stage B or high CV risk, to prevent HF hospitalization: an SGLT2 inhibitor such as empagliflozin, dapagliflozin, or canagliflozin (grade A), or semaglutide (grade B) Rec 10.44c

→

Stage C: treat symptomatic heart failure

- HFrEF or HFpEF: dapagliflozin, empagliflozin, or sotagliflozin Recs 10.41a, 10.41b
- **NEW** Obesity with HFpEF: tirzepatide (grade A) or semaglutide (grade B for HF events) Recs 10.44d, 10.44e
- **NEW** LVEF ≥40%: finerenone (FINEARTS-HF), never with spironolactone or eplerenone Rec 10.44h
- Metformin can continue in stable HF with eGFR >30 Rec 10.45

Why obesity with HFpEF now has its own lane

SUMMIT: tirzepatide in HFpEF with obesity (n = 731)

0.62
hazard ratio for CV death or worsening HF (9.9% vs 15.3%)

−13.9%
body weight at 52 weeks, vs −2.2% with placebo

19.5
point KCCQ symptom score gain, vs 12.7 with placebo

For HF events: why tirzepatide is grade A and semaglutide grade B

A **Tirzepatide:** HF events were a primary endpoint of SUMMIT, and it was positive

B **Semaglutide:** STEP-HFpEF DM tested symptoms and weight; fewer events seen only in a later pooled analysis

Symptoms: grade A for both. The letter rates the evidence, not the drug, and there is no head-to-head trial Recs 10.44d, 10.44e

Clinical pearl

- Natriuretic peptides run low in obesity, and SUMMIT did not require them
- Exertional dyspnea and edema in a patient labeled "deconditioned" may be HFpEF: get an echo
- SGLT2 inhibitors remain the foundation for HFrEF and HFpEF Rec 9.8

SECTION 11 · CHRONIC KIDNEY DISEASE

Kidney protection: give every layer the patient qualifies for

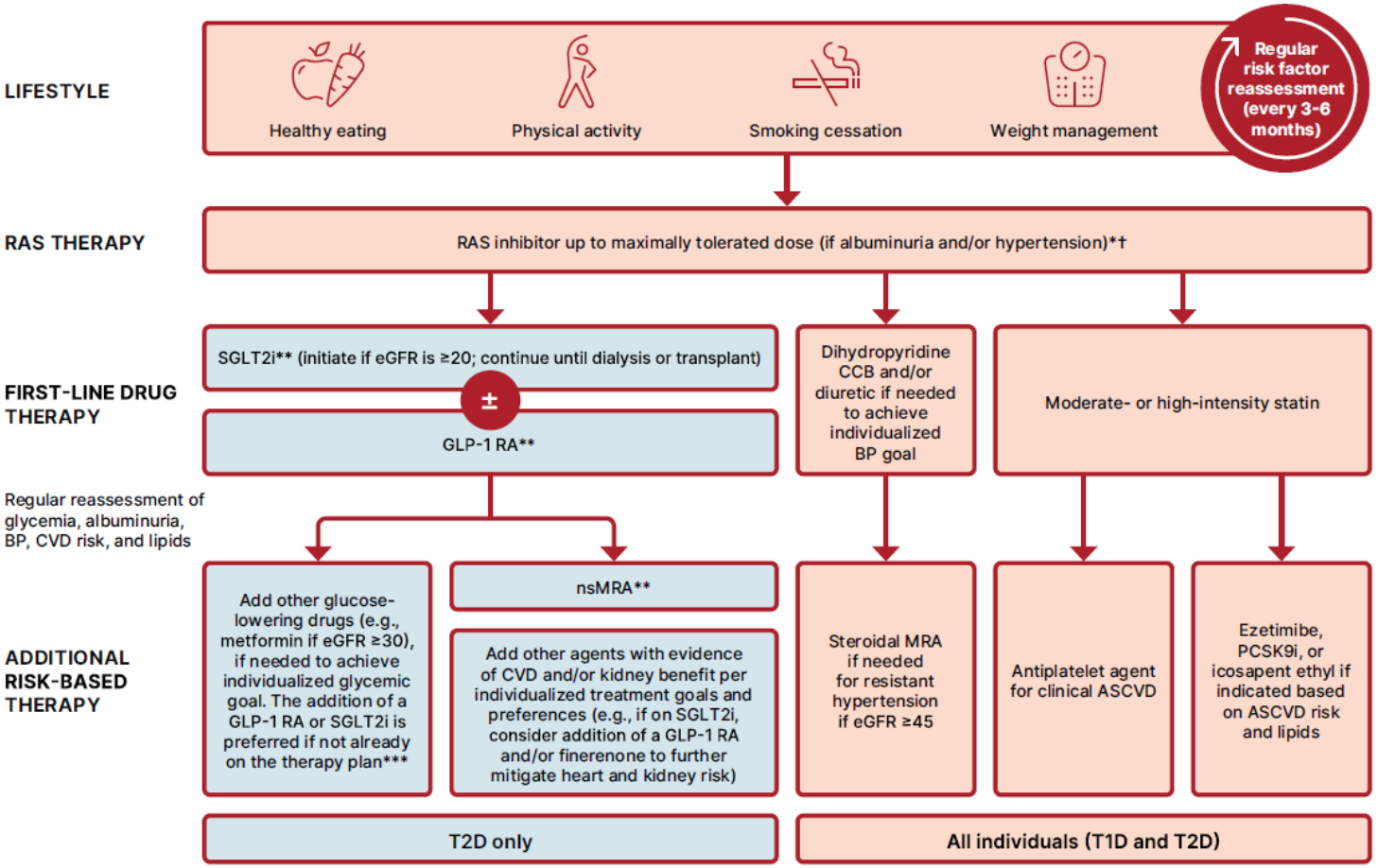
They add up, not substitute: the trials of drugs 2 to 4 were run on top of an ACE inhibitor or ARB

1	**ACE inhibitor or ARB** to the maximum tolerated dose	Albuminuria (UACR ≥30 mg/g) or hypertension; keep it through a creatinine rise of up to 30% Recs 11.6a, 11.6d
2	**SGLT2 inhibitor** canagliflozin, dapagliflozin, or empagliflozin	Everyone with type 2 diabetes and CKD: start at eGFR ≥20 and continue until dialysis or transplant Rec 11.7a
3	**GLP-1 RA** semaglutide (FLOW trial)	Type 2 diabetes and CKD, also to lower CV risk; which to start first, and whether to combine with the SGLT2 inhibitor, is clinical judgment Rec 11.7b
4	**Finerenone** nonsteroidal MRA	CKD with albuminuria (UACR ≥30 mg/g) and eGFR ≥25; check potassium at 1 month Rec 11.8. Since September 2026, also FDA-approved in type 1 diabetes

NEW **Start the SGLT2 inhibitor and finerenone on the same day only if ALL four apply:** type 2 diabetes, UACR ≥100 mg/g, eGFR 30 to 90, and already on a RAS inhibitor Rec 11.9. Otherwise, start the SGLT2 inhibitor and add finerenone if albuminuria persists.

Foundation for everyone: lifestyle, glycemia, and BP <130/80 with systolic ≤120 encouraged Rec 11.5; screen UACR and eGFR at least yearly Rec 11.1a

11. Chronic Kidney Disease and Risk Management



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

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

American Diabetes Association.

SECTION 11 · NEW

Start together, and keep protection as eGFR falls

1 Start together

NEW An SGLT2 inhibitor and finerenone on the same day, **only if ALL four apply** Rec 11.9, grade B

- **Type 2 diabetes**
- **UACR ≥100 mg/g**
- **eGFR 30 to 90**
- **On a RAS inhibitor**

–52% albuminuria at 6 months with both, about 30% more than either drug alone (CONFIDENCE, 800 adults)

A surrogate endpoint: it shows that starting both at once is safe

2 Keep protection as eGFR falls

NEW eGFR <20, not on dialysis

Keep the SGLT2 inhibitor Rec 11.11a

NEW On dialysis

Start or continue semaglutide, dulaglutide, liraglutide, or tirzepatide; not exenatide or lixisenatide Rec 11.11b

Refer to nephrology: rising albuminuria, falling eGFR, eGFR <30, or an unclear cause Recs 11.12a, 11.12b

MASLD: screen with FIB-4, then treat by fibrosis risk

>70%

of US adults with type 2 diabetes have MASLD

SCREEN

1. FIB-4 from age, AST, ALT, and platelets
2. FIB-4 1.3 or higher: elastography, or ELF
3. 8 kPa or more, or FIB-4 above 2.67: liver specialist

Adults with type 2 diabetes or prediabetes Recs 4.22a to 4.24; ADA pathway on the next slide

Treat by risk

Everyone	Structured lifestyle program for weight loss Rec 4.25
Overweight or obesity	Semaglutide (grade A) or tirzepatide (grade B) Rec 4.26
MASH or high fibrosis risk	NEW Semaglutide preferred (grade A); pioglitazone or tirzepatide can be considered (grade B) Rec 4.27a
F2 to F3 fibrosis	Resmetirom, through hepatology Rec 4.28
Decompensated cirrhosis	Insulin only Rec 4.30b

Semaglutide is the only glucose-lowering or obesity drug FDA-approved for MASH. ESSENCE, 72 weeks: MASH resolved in 63% vs 34% on placebo; fibrosis improved in 37% vs 22%

4. Comprehensive Medical Evaluation and Assessment of Comorbidities

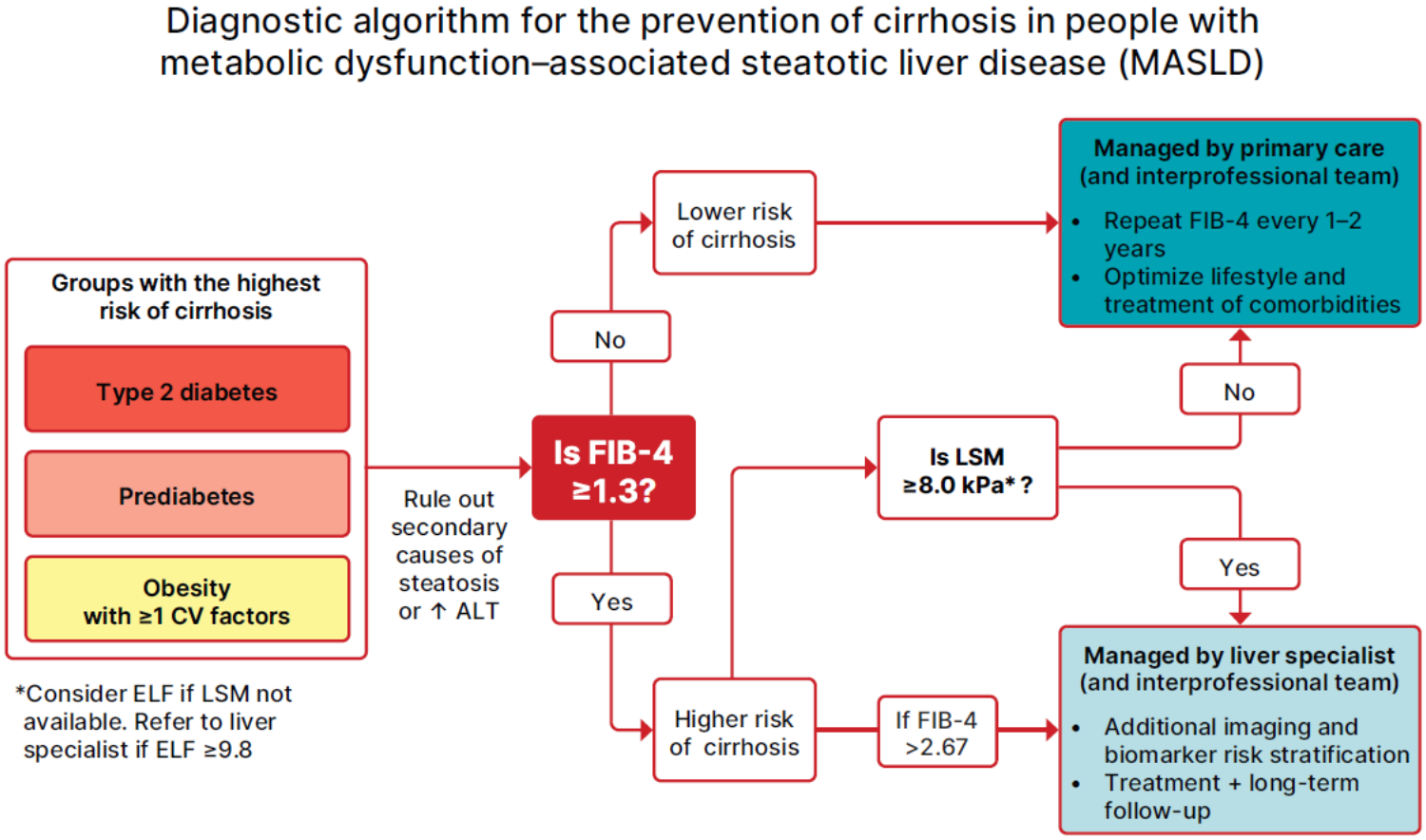
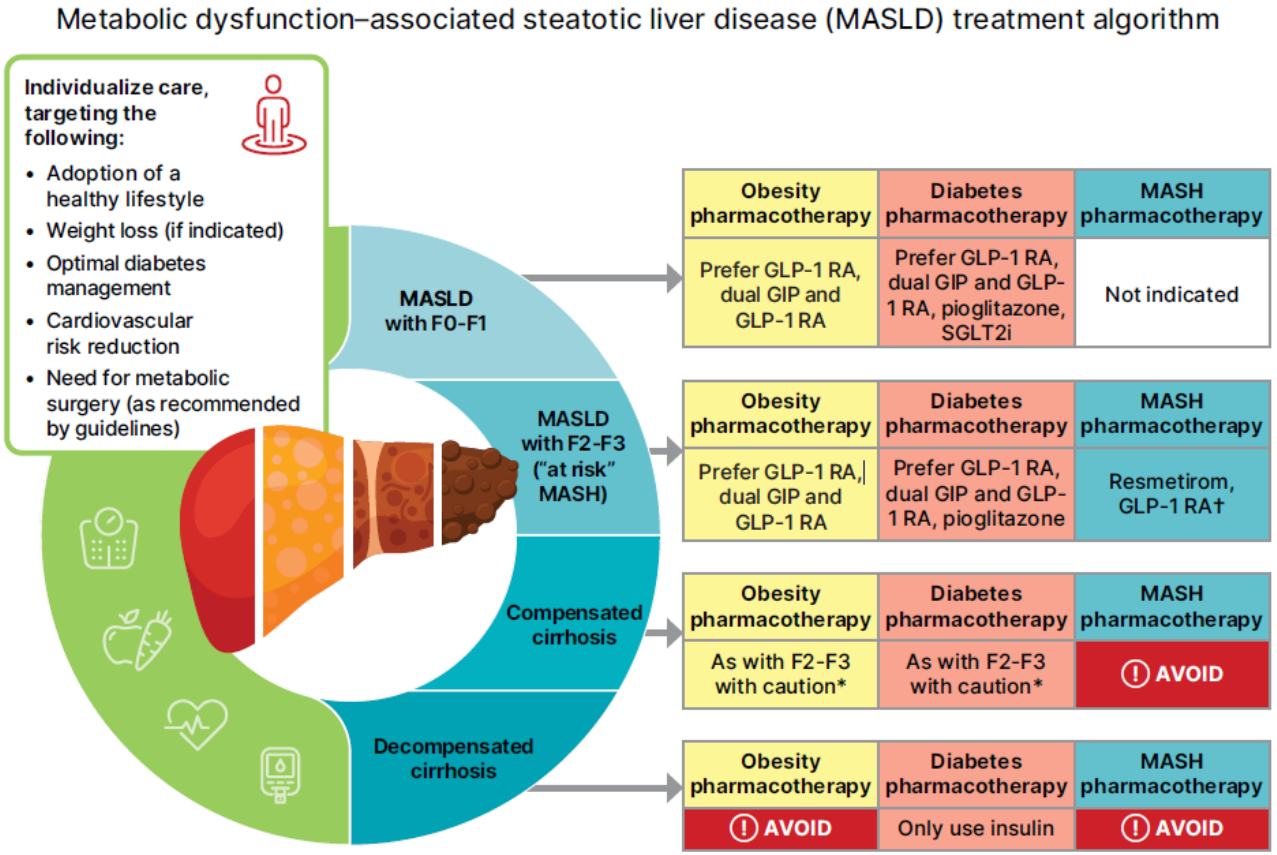


Figure 4.2—Diagnostic algorithm for risk stratification and the prevention of cirrhosis in individuals with metabolic dysfunction-associated steatotic liver disease (MASLD). CV, cardiovascular; ELF, enhanced liver fibrosis test; FIB-4, fibrosis-4 index; LSM, liver stiffness measurement, as measured by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

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

American Diabetes Association.

4. Comprehensive Medical Evaluation and Assessment of Comorbidities



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

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

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

American Diabetes Association.

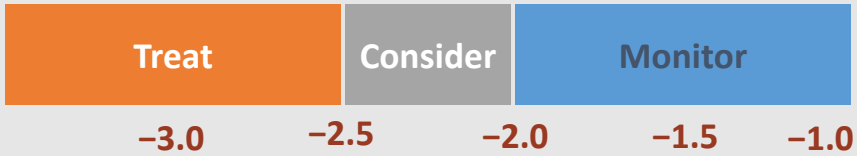
Eyes, nerves, and feet: when to check, how, and how to treat

	Eyes	Nerves	Feet
When	Type 2: at diagnosis. Type 1: after 5 years. Then yearly, or every 1 to 2 years if no retinopathy and at goal Recs 12.3 to 12.5	Type 2: at diagnosis. Type 1: after 5 years. Then at least yearly Rec 12.17	Full foot exam at least yearly; look at the feet every visit after sensory loss or an ulcer Recs 12.23, 12.25
How	Dilated exam, retinal photos read remotely, or FDA-approved AI Rec 12.6	Pinprick or temperature, plus 128-Hz vibration; 10-g monofilament every year Rec 12.18	Inspect skin and shape; monofilament or Ipswich touch test, plus pinprick, temperature, or vibration; feel the pulses Rec 12.24
Treat	Macular edema involving the center: anti-VEGF injections first Rec 12.12	Pain: gabapentinoid, SNRI, tricyclic, or sodium channel blocker; combine for more relief; no opioids Rec 12.22	Ulcer not healing with standard care: advanced therapy, such as negative-pressure wound therapy Rec 12.32
New in 2026	GLP-1 RAs: data on optic neuropathy and macular degeneration conflict; check the retina when intensifying	Ipswich touch test added to the exam text; combining pain drugs now recommended Rec 12.22	Home foot-temperature monitoring (mats, insoles, socks) can flag an ulcer early

Treat osteoporosis earlier in people with diabetes

In diabetes, read a T-score of −2.0 like −2.5

Type 2 diabetes raises fracture risk despite normal or higher BMD, and FRAX underestimates it.



Treat: T-score ≤−2.5, fragility fracture, or FRAX ≥3% hip or ≥20% major Rec 4.13a

NEW Consider at −2.0 to −2.5 with added risk factors Rec 4.13b

Who gets DXA

Age 65 or older, and younger with risk factors, every 2 to 3 years Rec 4.9

Drug choice

Avoid TZDs and sulfonylureas when fracture risk is high; avoid hypoglycemia to prevent falls Recs 4.10, 4.11

Basics

Calcium 1,000 to 1,200 mg/day plus vitamin D Rec 4.12

Older adults: prevent lows first, then match goals to health

GOALS BY HEALTH STATUS

Healthy	A1C <7.0 to 7.5%; time in range ≥70%; time below range ≤4% Rec 13.7a
Complex or intermediate	Less stringent, such as A1C <8.0% and time in range ≥50% Rec 13.7b
Very complex or poor health	Focus on avoiding lows and symptomatic highs, not an A1C number Rec 13.7c

Prevent lows first

- Ask about lows at every visit Rec 13.4
- Choose drugs with low hypoglycemia risk Rec 13.13
- **NEW** CGM for type 1, and for type 2 on insulin Rec 13.5
- AID or connected pens, if the person can manage them Rec 13.6
- If risk stays high: step down or switch insulin, sulfonylureas, and meglitinides, and simplify; keep cardiorenal drugs Recs 13.14a to 13.14d

Also new: BP <130/80 when safe, <140/90 with poor health Rec 13.9; protein ≥0.8 g/kg/day Rec 13.11a

SECTION 13 · POST-ACUTE AND LONG-TERM CARE (PALTC)

Nursing homes and assisted living: plan for lows between visits

PALTC (post-acute and long-term care) now covers skilled nursing or rehab after a hospital stay, nursing homes, and assisted living

Why it is different

- Residents are especially prone to lows: impaired cognition and kidney function, variable intake, many medicines
- Clinicians may see residents only every 30 to 60 days, so staff must catch problems
- Oral agents can work as well as basal insulin in type 2

What to do

- Train staff, including on CGM, pumps, and AID Rec 13.16
- Set goals and pick drugs and devices after assessing mobility, mentation, medications, and preferences Rec 13.17
- Erratic meals: rapid-acting insulin given right after eating, matched to intake, may help
- CGM can help catch lows in residents on insulin

Call the clinician

Now

Glucose <70 mg/dL; treat without waiting

As soon as possible

- 70 to 100 mg/dL
- Two or more >250 in 24 h with a change in condition
- Consistently >250 over 24 h, or >300 for 2 days
- Meter reads too high to measure
- Sick: vomiting, fever, lethargy, or poor intake

SECTION 15 · PRECONCEPTION · NEW

Pregnancy planning now includes a GLP-1 exit plan

1. **Stop GLP-1 RA or tirzepatide before conception**
   NEW Semaglutide label: at least 2 months ahead; US tirzepatide label gives no interval (Canadian label: 1 month)

2. **Use contraception while taking them**
   Tirzepatide lowers oral contraceptive levels: add a barrier method for 4 weeks after starting and after each dose increase

3. **Bridge to insulin and reach preconception goals**
   NEW Premeal 80 to 110 and 2-h <155 mg/dL; A1C <6.5% if safe Rec 15.3

4. **Stop other drugs that can harm a pregnancy**
   ACE inhibitors, ARBs, MRAs Rec 15.25a; lipid-lowering drugs in most cases Rec 10.25

Counseling evidence

51,826

pregnancies with type 2 diabetes: no more major malformations with periconceptional GLP-1 RA than with insulin (JAMA Intern Med 2023)

+3.3 kg

gestational weight gain after stopping a GLP-1 RA before or early in pregnancy, with more preterm birth, diabetes in pregnancy, and hypertensive disorders (JAMA 2025)

Reassuring after an unplanned exposure; stopping is a risk period of its own

Pregnancy, stage by stage: from planning to postpartum

Planning

- A1C <6.5% if safe Rec 15.3
- **NEW** Stop GLP-1-based drugs; bridge to insulin
- Stop ACE inhibitors, ARBs, MRAs Rec 15.25a

Before 15 weeks

- Test for undiagnosed diabetes if risk factors; consider for all Rec 2.31a
- **NEW** A1C 5.9 to 6.4% or FPG 110 to 125: early abnormal glucose Rec 2.31b
- Benefit of early treatment uncertain: nutrition, fasting checks; consider treating if FPG ≥110

24 to 28 weeks

- Test for GDM unless already diagnosed Rec 2.32
- One step: 75-g OGTT; any of fasting ≥92, 1-h ≥180, 2-h ≥153
- Or two step: 50-g screen, then 100-g OGTT (2 values)

Goals in pregnancy

- Fasting <95; 1-h <140 or 2-h <120 Rec 15.8
- A1C <6%, or <7% if needed Rec 15.9
- Type 1: CGM, and AID with pregnancy targets Recs 15.11, 15.19
- Treat BP at 140/90 Rec 15.24

Postpartum

- Insulin needs drop sharply Rec 15.26
- After GDM: 75-g OGTT at 4 to 12 weeks Rec 15.30, then every 1 to 3 years Rec 15.31
- **NEW** A1C at 6 to 12 months adds information; does not replace the OGTT

In the hospital: targets by setting, and coming off the drip

1 NEW Before surgery

- A1C <8% within 3 months of elective surgery, or 14-day GMI <8% or time in range >50% Rec 16.14
- 100 to 180 mg/dL before, during, and after surgery Rec 16.15
- Hold SGLT2 inhibitors 3 to 4 days; plan GLP-1 RAs case by case

2 ICU

- Start insulin at ≥180 mg/dL, confirmed twice in 24 h Rec 16.4a
- Target 140 to 180 mg/dL Rec 16.5a
- Continuous IV insulin infusion Rec 16.8a

3 Ward

- A1C on admission if none in 3 months Rec 16.1
- Target 100 to 180 mg/dL if safe Rec 16.5b
- Basal, prandial, and correction insulin; no sliding scale alone Recs 16.9, 16.10
- Keep personal CGM, pumps, and AID under protocol Recs 16.6, 16.7

Coming off IV insulin

Give SC basal insulin at least 2 hours before stopping the infusion, so glucose does not rebound. In DKA or HHS, switch only after the crisis resolves and the person can eat (next slide).

SECTION 16 · HYPERGLYCEMIC CRISES · NEW

DKA and HHS: diagnose, treat, then switch to SC insulin

All must be met	DKA	HHS
Glucose	≥200 mg/dL, or known diabetes	≥600 mg/dL
Ketones	BHB ≥3.0 mmol/L, or urine ketones ≥2+	BHB <3.0, or urine ketones <2+
Acid-base	pH <7.3 and/or bicarbonate <18	pH ≥7.3 and bicarbonate ≥15
Osmolality	Not a criterion	Effective >300, or total >320 mOsm/kg

About 10% of DKA is euglycemic (glucose <200): think SGLT2 inhibitors. BHB, beta-hydroxybutyrate Table 16.1

Treat all three together Figure 16.1; 2024 consensus

1 **Fluids** — 0.9% saline or other crystalloid; add 5 to 10% dextrose when glucose falls below 250

2 **Potassium** — **Below 3.5: hold insulin;** give 10 to 20 mmol/h until above 3.5. 3.5 to 5.0: add to each liter. Above 5.0: none. Recheck 2 h after insulin starts, then every 4 h

3 **Insulin** — Mild DKA: SC rapid-acting. Moderate or severe DKA: IV 0.1 units/kg/h. HHS: IV 0.05 units/kg/h. Glucose <250: reduce to 0.05 units/kg/h

When to switch to SC insulin

Bicarbonate only if pH <7.0; teach prevention before discharge Rec 16.17

1 Crisis resolved
DKA: pH >7.3 or bicarbonate >18, and ketones <0.6. HHS: osmolality <300, urine output >0.5 mL/kg/h, glucose <250

→ **2 Eating and drinking**
Start a SC multidose plan: basal plus mealtime insulin

→ **3 Overlap, then stop**
Give SC basal insulin at least 2 hours before stopping the drip, to prevent rebound ketoacidosis

HOW AACE 2026 COMPARES

ADA and AACE mostly agree, with a few differences

Topic	ADA Standards 2026	AACE algorithm 2026
A1C goal for most adults	Below 7%, lower if safe	6.5% or less if safe
Blood pressure	Below 130/80; systolic below 120 encouraged at high risk	Below 130/80; below 120/70 considered at high risk
Hypercortisolism	Not a 2026 recommendation	Targeted screening (case-finding) in difficult-to-control type 2 diabetes (CATALYST)
Liver	GLP-1 RA with MASH benefit preferred in MASH	MASLD at the top of a complication-centric algorithm
Combination therapy	Consider at the start; usually needed at 1.5% or more above goal	Two agents at 1.5% or more above goal

Sources: ADA Standards of Care in Diabetes 2026; AACE 2026 type 2 diabetes consensus algorithm (Endocrine Practice)

TAKE HOME

Ten things to take home

1. Steroids and cancer drugs: monitor glucose on a schedule; consider metformin early
2. CGM at diagnosis for anyone on insulin or hypoglycemia-causing drugs
3. AID is the preferred insulin delivery method in type 1 and insulin-requiring type 2
4. Screen yearly for distress, depression, anxiety, and fear of hypoglycemia
5. Obesity in type 1 diabetes: GLP-1-based therapy or surgery is on the table
6. Pick drugs by organ: heart, kidney, liver first; glycemia second
7. Systolic <120 mmHg for high cardiovascular or kidney risk, when safe
8. Obesity with symptomatic HFpEF: tirzepatide or semaglutide
9. UACR ≥100 mg/g: SGLT2 inhibitor plus finerenone together
10. MASH or high fibrosis risk: semaglutide is the preferred GLP-1 RA

DISCUSSION AND RESOURCES
Resources

- Standards of Care in Diabetes 2026: Diabetes Care 2026;49(Suppl 1), with online updates between editions
- ADA Standards of Care app and slide deck (DiabetesPro)
- "Your Rights and Care Standards," ADA patient guide for type 2 diabetes
- ADA Standards of Care in Overweight and Obesity
- AACE 2026 type 2 diabetes algorithm, Endocrine Practice