Sentara® Health Plans

SENTARA HEALTH PLANS CLINICAL PRACTICE GUIDELINE:

DIABETES CARE - ANNUAL

Guideline History

Date Approved	02/94
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Guideline Change Summary

Date	Description
1/2026	Review and recommendations completed by Dr. Sangeeta Panwar for presentation to committee on 1/16/2026. Updated the Standards of Care Diabetes to 2026 Version and included the 2026 Summary of Revisions

Summary of Revisions: Standards of Care in Diabetes—2026

*American Diabetes Association Professional Practice Committee for Diabetes**

Diabetes Care 2026;49(Suppl. 1):S6–S12 | https://doi.org/10.2337/dc26-SREV

GENERAL CHANGES

The field of diabetes care is rapidly changing as new research, technology, and treatments that can improve the health and well-being of people with diabetes continue to emerge. With annual updates since 1989, the American Diabetes Association has long been a leader in producing guidelines that capture the most current state of the field.

The 2026 "Standards of Care in Diabetes" has continued to incorporate person-first and inclusive language. Efforts were made to consistently apply terminology that empowers people with diabetes and recognizes the individual at the center of diabetes care. Minor updates were made to figures and tables to align with current accessibility standards.

Although levels of evidence for several recommendations have been updated, these changes are not outlined below where the clinical recommendation has remained the same. That is, changes in evidence level from, for example, **E** to **C**, are not noted below. The 2026 Standards of Care contains, in addition to many minor changes that clarify recommendations or reflect new evidence, more substantive revisions detailed below.

SECTION CHANGES

Endorsements

For the third consecutive year, the "Bone Heath" subsection in section 4, "Comprehensive Medical Evaluation and Assessment of Comorbidities," received endorsement from the American Society for Bone and Mineral Research and section 8, "Obesity and Weight Management for the Prevention of Diabetes," received endorsement from The Obesity Society. For the eighth consecutive year, section 10, "Cardiovascular Disease and Risk Management," received endorsement from the American College of Cardiology. For the second consecutive year, section 13, "Older Adults," received endorsement from the American Geriatrics Society. For the first time, section 11, "Chronic Kidney Disease and Risk Management," and section 14, "Children and Adolescent," received endorsement from the National Kidney Foundation and the International Society for Pediatric and Adolescent Diabetes, respectively.

1. Improving Care and Promoting Health in Populations

(https://doi.org/10.2337/dc26-S001)

Recommendation 1.1 was revised to highlight the importance of shared decision-making based on individual values, preferences, prognoses, comorbidities, and informed financial considerations.

Recommendation 1.5 was updated to emphasize the importance of continuous quality improvement by health systems to improve quality of care and health outcomes.

Recommendation 1.8 was revised to include consideration of digital self-management tools or coaches as appropriate to provide support for people with diabetes.

Recommendation 1.9 was modified to highlight the important role of community health workers in supporting the management of kidney disease risk factors, in addition to diabetes and cardiovascular disease risk factors, in underserved communities and health care systems.

Table 1.1 was enhanced to specify additional care team members whose expertise may be beneficial for older adults with diabetes.

2. Diagnosis and Classification of Diabetes

(https://doi.org/10.2337/dc26-S002)

Recommendation 2.8 was divided into two components to emphasize the importance of prompt evaluation for stage 3, overt type 1 diabetes in people with one or more islet autoantibodies

**A complete list of members of the American Diabetes Association Professional Practice Committee for Diabetes can be found at https://doi.org/10.2337/dc26-SINT.*

Duality of interest information for each contributor is available at https://doi.org/10.2337/dc26-SDIS.

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(Recommendation 2.8a); Recommendation 2.8b maintains the original guidance that people with multiple islet autoantibodies should be referred to a specialized center for education and possibly preventative interventions.

Recommendation 2.9 was added to highlight that people with a confirmed single IA-2 autoantibody should be monitored similarly to people with stage 2 type 1 diabetes but negative for IA-2 autoantibodies, as they have a comparable risk of progression to stage 3.

Recommendation 2.18 was added to reinforce monitoring of postprandial or random plasma glucose in the setting of recurrent or long-term treatment with glucocorticoids.

Recommendation 2.19 was added to underscore the role of counseling and education regarding the risk of hyperglycemia in people initiating treatment with immune checkpoint inhibitors, phosphoinositidylinositol 3-kinase α (PI3Kα) inhibitors, and other anticancer therapy medications.

Recommendation 2.20 was added to provide guidance regarding plasma glucose monitoring at each visit in people treated with immune checkpoint inhibitors.

Recommendation 2.21 was added to emphasize close monitoring of plasma glucose in people initiating treatment with PI3Kα inhibitors, which are associated with a particularly high risk of hyperglycemia during the first weeks of treatment.

Recommendation 2.22 was added to prompt fasting or random plasma glucose monitoring at each visit in people treated with mammalian target of rapamycin (mTOR) inhibitors.

Recommendation 2.24a was updated to reiterate that, when feasible, an annual oral glucose tolerance test (OGTT) starting at the age of 10 years is the preferred screening test for cystic fibrosis–related diabetes.

Recommendation 2.24b was modified to highlight that A1C can be used as a part of an alternative two-step screening strategy for cystic fibrosis–related diabetes when OGTT is not feasible.

Previous Recommendations 2.26b and 2.26c on gestational diabetes mellitus screening were consolidated and updated and are now Recommendation 2.31b; the associated narrative text was moved to section 15, "Diabetes Management in Pregnancy," and updated to reflect recent evidence and controversies in the management of early abnormal glucose metabolism in pregnancy. The text in the "Gestational Diabetes Mellitus" subsection was updated and more closely integrated with the information in section 15, "Diabetes Management in Pregnancy."

3. Prevention or Delay of Diabetes and Associated Comorbidities

(https://doi.org/10.2337/dc26-S003)

Recommendation 3.1 was broadened to include monitoring of progression from prediabetes to all types of diabetes, not only type 2 diabetes.

Recommendation 3.2 was enhanced to include consideration of continuous glucose monitoring (CGM) data when monitoring for disease progression among individuals with presymptomatic type 1 diabetes.

Recommendation 3.3 was clarified to recommend referral of individuals with overweight or obesity at high risk for type 2 diabetes to a diabetes prevention program with the goal of achieving and maintaining weight reduction of at least 5–7% of initial body weight.

Recommendation 3.4 was revised to focus on eating patterns with the strongest evidence base for preventing type 2 diabetes, including Mediterranean and low carbohydrate eating patterns.

Recommendation 3.6 was clarified to indicate that certified technology-assisted diabetes prevention programs can be delivered through smartphones, web-based applications, and telehealth modalities.

Recommendation 3.8 was added to recommend considering using metformin to prevent hyperglycemia in high-risk individuals treated with a PI3Kα inhibitor (e.g., alpelisib and inavolisib).

Recommendation 3.9 was added to recommend considering using metformin to prevent hyperglycemia in high-risk individuals treated with high-dose glucocorticoids.

4. Comprehensive Medical Evaluation and Assessment of Comorbidities

(https://doi.org/10.2337/dc26-S004)

Recommendation 4.3 was changed to include assessment for glycemic status and previous and current treatment at the initial visit and follow-up visits as appropriate. Support systems and available resources were added in addition to identifying care partners at the initial visit and follow-up visits as appropriate.

Recommendation 4.5, regarding vaccinations, was revised to include adolescents.

Recommendation 4.13a was revised to recommend considering osteoporosis drug therapy in older adults with increased risk of fracture with a T-score ≤ -2.5, and Recommendation 4.13b was added to state that treatment may be considered in adults with diabetes with a T-score between -2.0 and -2.5 in the presence of additional fracture risk.

Recommendation 4.26 was updated to specify that a glucagon-like peptide 1 receptor agonist (GLP-1 RA) with demonstrated benefits in metabolic dysfunction–associated steatohepatitis (MASH) can be considered for treatment in adults with type 2 diabetes, metabolic dysfunction–associated steatotic liver disease (MASLD), and overweight or obesity.

Recommendation 4.27a was updated to specify that a GLP-1 RA with demonstrated benefit is preferred for glycemic management due to beneficial effects on MASH in adults with type 2 diabetes and biopsy-proven MASH or those at high risk for liver fibrosis.

In **Fig. 4.1**, MASLD was added to be considered as a specific factor that impacts choice of treatment.

Figure 4.2 was modified to clarify that the algorithm for individuals with fibrosis-4 (FIB-4) index >2.67 should be managed by a liver specialist.

Figure 4.3 was modified to include a GLP-1 RA with demonstrated benefit for MASH pharmacotherapy in individuals with MASLD and high risk for MASH.

5. Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes

(https://doi.org/10.2337/dc26-S005)

Recommendation 5.4 was revised to recommend using behavioral strategies to support diabetes self-management education and support (DSMES) and engagement in positive health behaviors.

Recommendation 5.5 was modified to state that DSMES should be culturally and socially appropriate based on personal preferences and needs and that DSMES participation should be communicated with the diabetes care team.

Recommendation 5.12 was revised to advise that an overweight or obesity treatment plan including nutrition, physical activity, and behavioral health support should be provided to aim for at least 5–7% weight loss from baseline body weight.

Recommendation 5.23 was amended to recommend counseling and regular

monitoring for individuals pursuing intentional weight loss on adequate nutrition intake.

Recommendation 5.32 was modified to state that the updated comprehensive prefasting risk assessment should be used to generate a risk score for the safety of religious fasting.

Recommendation 5.34 was modified to encourage increases in physical activity levels with the goal of meeting activity guidelines, and the narrative discussion on the role of physical activity during obesity treatment was updated.

Recommendation 5.40 was revised to recommend routine assessment and avoidance of tobacco and e-cigarette/vaping use. It also suggests providing or referring individuals for combination treatment, which includes tobacco and e-cigarette/vaping cessation counseling and pharmacologic therapy.

Recommendation 5.45 was updated to recommend referral to a qualified behavioral health professional if diabetes distress is not adequately addressed during the medical appointment.

Recommendation 5.46 was updated to recommend screening for anxiety symptoms at least annually in people with diabetes and encourage health care professionals to address anxiety symptoms within their scope of practice.

Recommendation 5.47 was updated to recommend screening individuals at high risk for hypoglycemia or with severe or frequent hypoglycemia for fear of hypoglycemia at least annually or when clinically appropriate and to refer to a trained health care professional for evidence-based intervention.

Recommendation 5.56 was amended to recommend screening for sleep health in people with diabetes and in those at risk for diabetes.

Table 5.3 now contains updated criteria for the comprehensive prefasting risk assessment for people with diabetes who seek to fast during Ramadan.

6. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises

(https://doi.org/10.2337/dc26-S006)

Recommendation 6.17 was added to promote inclusion of oral glucose in first aid kits for use in treating hypoglycemia in workplaces, schools, and other institutions and public settings.

The section "Intercurrent Illness" was expanded to include criteria for holding specific diabetes medication classes during acute illness.

The section "Hyperglycemic Crises: Diagnosis, Management, and Prevention" was revised to include more content on the outpatient prevention and management of diabetic ketoacidosis. Reflecting this expanded content, "Hyperglycemic Crises" was added to the section title.

Figure 6.1, which shows an individualized approach to setting glycemic goals, was expanded to include individualized goals for CGM metrics based on health status and other person- and treatment-specific factors.

7. Diabetes Technology

(https://doi.org/10.2337/dc26-S007)

Recommendations were added regarding education and training of people with diabetes and health care professionals based on the type of device. In the narrative text, more details were added about education and training based on the type of device. Major updates include content about the support health care professionals may need and information about device initiation for different types of diabetes.

Recommendation 7.3 was divided into two recommendations and includes guidance regarding prescribing and initiating device use. Recommendation 7.3a discusses prescribing, initiating, and following a CGM device, and Recommendation 7.3b describes the same aspects for automated insulin delivery (AID) systems.

Recommendation 7.6 was changed to specify children and adolescents in a school setting and states that children and adolescents should be supported at school in the use of diabetes technology, such as CGM systems, continuous subcutaneous insulin infusion (CSII), connected insulin pens, and AID systems. Older students (aged ≥18 years) are discussed in the new Recommendation 7.7, which also discusses workplace accommodation. Recommendation 7.7, for those aged ≥18 years, states that 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.

Recommendation 7.8 discusses early initiation of all devices, as indicated based on a person's circumstances. New Recommendation 7.8a states that there should be no requirement of C-peptide level, the presence of islet autoantibodies, or duration of insulin treatment before initiation of CSII or AID.

The "Blood Glucose Monitoring" section includes updated literature highlighting the benefits of glucose monitoring for people with type 2 diabetes. Additionally, it reinforces the importance of ensuring that individuals using CGM also have access to blood glucose monitoring.

Recommendation 7.15 states that use of CGM is now recommended at diabetes onset and anytime thereafter for children, adolescents, and adults with diabetes who are on insulin therapy, on noninsulin therapies that can cause hypoglycemia, and on any diabetes treatment where CGM helps in management.

Recommendation 7.17 briefly discusses use of diabetes devices in pregnancy, which is discussed in detail in section 15, "Diabetes Management in Pregnancy."

Recommendation 7.25a states that AID systems are the preferred insulin delivery system for people with type 1 diabetes and adults and children with type 2 diabetes on multiple daily injections, CSII, or sensor-augmented pump therapy and for other forms of insulin-deficient diabetes.

Recommendation 7.25b states that AID systems can be considered in people with type 2 diabetes on basal insulin who are not meeting their individualized glycemic goals.

The narrative text further discusses that the benefits of CGM have been shown regardless of age, sex, education or income levels, or baseline diabetes characteristics.

Table 7.3 provides updated definitions of types of CGM devices. Intermittently scanned CGM (isCGM) is no longer discussed, although it is referenced as an older option. The three types of devices are now real-time CGM (rtCGM), over-the-counter CGM (OTC-CGM), and professional CGM.

8. Obesity and Weight Management for the Prevention and Treatment of Diabetes

(https://doi.org/10.2337/dc26-S008)

Recommendation 8.2a was updated to state that screening for overweight and obesity should occur annually using BMI and that an additional measurement of body fat (e.g., anthropometric assessment or direct measurement) should be

incorporated to confirm excess adiposity where available and feasible.

Recommendation 8.5 was revised to clarify that weight loss of 5–7% of baseline body weight improves glycemia and other intermediate cardiovascular risk factors.

Recommendation 8.8b was updated to clarify components of alternative structured lifestyle programs and examples of modes of delivery.

Recommendation 8.14 was amended to recommend counseling and regular monitoring for individuals pursuing intentional weight loss on adequate nutrition intake.

Recommendation 8.15 was modified to recommend engaging other care team members to minimize use of weight-promoting medications whenever clinically appropriate.

Recommendation 8.20 was added to state that the individualized dose and dose titration for obesity pharmacotherapy should balance efficacy, benefits, and tolerability.

Recommendation 8.21 on treatment modification and intensification approaches now includes considering alternative pharmacologic agents.

Recommendation 8.29 was added to include GLP-1 RA–based therapy and/or metabolic surgery as treatment options for obesity in people with type 1 diabetes.

Table 8.2 was updated with obesity pharmacotherapy costs as of 15 July 2025.

9. Pharmacologic Approaches to Glycemic Treatment

(https://doi.org/10.2337/dc25-S009)

For the glycemic treatment plan for people with type 2 diabetes and symptomatic heart failure with preserved ejection fraction (HFpEF), Recommendation 9.9a was added to recommend use of a dual glucose-dependent insulinotropic polypeptide (GIP) and GLP-1 RA with demonstrated benefits for heart failure–related symptoms and reduction in heart failure events, and Recommendation 9.9b was revised to include a GLP-1 RA with demonstrated benefits in heart failure–related symptoms and/or reduction in heart failure events.

Recommendation 9.11 was updated to include information about initiation and continuation of a GLP-1–based therapy for people with type 2 diabetes and advanced chronic kidney disease (CKD).

Recommendation 9.12 was revised to recommend a GLP-1 RA with demonstrated benefits in MASH or a dual GIP and GLP-1 RA with potential benefits in MASH in people with type 2 diabetes, MASLD, and overweight or obesity for glycemic management.

Recommendation 9.13a was changed to state that a GLP-1 RA with beneficial effects on MASH is preferred for glycemic management and a pioglitazone or a dual GIP and GLP-1 RA with potential beneficial effects on MASH can be considered for glycemic management in adults with type 2 diabetes, biopsy-proven MASH, or those at high risk for liver fibrosis.

Recommendation 9.24 was revised to include healthy behaviors, DSMES, avoidance of therapeutic inertia, and social determinants of health as essential components of the glycemic treatment plan in all people with diabetes.

Recommendation 9.25 was updated to recommend use of CGM at diabetes onset and anytime thereafter for adults with diabetes on insulin therapy, on noninsulin therapies that can cause hypoglycemia, and on any diabetes treatment where CGM aids in management.

Recommendation 9.27 was modified to recommend that AID systems should be offered to all adults with type 1 or type 2 diabetes on insulin.

New recommendations for glycemic management in the context of cancer treatment were added. For individuals on immunotherapy who develop hyperglycemia, Recommendation 9.33 was added to recommend the assessment of these individuals for the need of insulin therapy to prevent potential diabetic ketoacidosis and to use additional testing to determine if hyperglycemia is related to immunotherapy-associated diabetes. For individuals with hyperglycemia due to mTOR inhibitors or PI3K inhibitors, Recommendations 9.34 and 9.35a state that metformin should be considered as first-line treatment, and Recommendation 9.35b states that insulin should be reserved for severe hyperglycemia and hyperglycemic crises due to its potential impact on PI3K inhibitor efficacy. For individuals undergoing glucocorticoid treatment, Recommendation 9.36 was added to recommend adjustment or initiation of additional glucose-lowering therapies to maintain individualized glycemic goals based on the glucocorticoid treatment plan and ongoing assessment of glucose levels.

New recommendations on glycemic treatment in the context of organ transplant were added for adults with post-transplantation diabetes mellitus or preexisting type 2 diabetes and undergoing organ transplantation. For glycemic management in the postoperative setting, Recommendation 9.37 was added to recommend that insulin is preferred and that a dipeptidyl peptidase 4 inhibitor can be considered for mild hyperglycemia. For long-term glycemic management, Recommendation 9.38a states that noninsulin pharmacotherapy can be used and that the selection of medication may be contingent upon the transplanted organ(s), and Recommendation 9.38b states that a GLP-1 RA can be considered due to additional cardiometabolic benefits. Recommendation 9.38c was added to recommend the addition of insulin to noninsulin pharmacotherapy if individualized long-term glycemic goals cannot be achieved or maintained.

A new insulin algorithm for type 1 diabetes (**Fig. 9.2**) was added.

Figure 9.4 was revised to include a dual GIP and GLP-1 RA or GLP-1 RA for glycemic management for those with type 2 diabetes, symptomatic HFpEF, MASLD or MASH, and obesity.

Figure 9.5 was revised to suggest considering CGM for individuals with type 2 diabetes on basal insulin.

Tables 9.3 and **9.4** were updated with glucose-lowering medication and insulin costs as of 15 July 2025.

10. Cardiovascular Disease and Risk Management

(https://doi.org/10.2337/dc26-S010)

Recommendation 10.4 was updated to state that a systolic blood pressure goal <120 mmHg should be encouraged for individuals with high cardiovascular or kidney risk.

Recommendation 10.6 was modified to indicate that blood pressure–lowering pharmacologic therapy should be titrated to achieve individualized blood pressure goals.

Recommendation 10.10 was revised to include that an ACE inhibitor or angiotensin receptor blocker (ARB) is strongly recommended to treat hypertension for those with severely increased albuminuria and/or estimated glomerular filtration rate (eGFR) <60 mL/min/1.73 m^2 to the maximally tolerated dose to prevent progression of kidney disease and to reduce cardiovascular events.

Recommendation 10.11 was modified to specify monitoring frequency for a drop in eGFR and increase in serum potassium levels when ACE inhibitors, ARBs, or mineralocorticoid receptor antagonists (MRAs) are used and monitoring frequency for hypokalemia when diuretics are used.

For individuals receiving statin therapy, Recommendation 10.32 was revised to advise against the addition of fibrate, niacin, or dietary supplements containing n-3 fatty acids, as they do not confer additional cardiovascular risk reduction.

Recommendation 10.40c was modified to include people with type 2 diabetes and CKD and to recommend a GLP-1 RA with demonstrated cardiovascular benefit to reduce the risk of cardiovascular events.

Recommendation 10.44c was updated to recommend a GLP-1 RA with heart failure prevention benefit for people with type 2 diabetes and asymptomatic (stage B) heart failure with high risk of or established cardiovascular disease.

Recommendations 10.44d and 10.44e were revised and added to recommend a dual GIP and GLP-1 RA or a GLP-1 RA with demonstrated benefit for reduction in heart failure events and heart failure symptoms, respectively, in adults with type 2 diabetes, obesity, and symptomatic heart failure with preserved ejection fraction.

Recommendation 10.44h was added to recommend a nonsteroidal MRA (nsMRA) with proven benefit in reducing worsening heart failure events for people with diabetes and symptomatic stage C heart failure with ejection fraction >40%.

Figure 10.5 was added to include an overview of prevention and treatment of symptomatic heart failure in people with diabetes, and **Fig. 10.6** was added to illustrate the approach to prevent atherosclerotic cardiovascular disease (ASCVD) in people with type 2 diabetes.

11. Chronic Kidney Disease and Risk Management

(https://doi.org/10.2337/dc26-S011)

Recommendation 11.1a was amended to clarify the frequency of assessment for kidney function.

Recommendation 11.5 was amended to clarify goals for blood pressure management with specific emphasis on systolic blood pressure goals.

Recommendation 11.6a was updated to clarify guidance on intolerance to medication in nonpregnant individuals with diabetes and hypertension.

Recommendation 11.6b was revised to specify monitoring frequency for a drop in eGFR and increase in serum potassium levels and for hypokalemia when ACE inhibitors, ARBs, or MRAs are used.

Recommendation 11.8 was changed to enhance clarity on potassium level monitoring after initiation of an nsMRA to reduce CKD progression and cardiovascular risk.

New Recommendation 11.9 was added to state that simultaneous initiation of a sodium–glucose cotransporter 2 (SGLT2) inhibitor and an nsMRA can be considered in individuals with type 2 diabetes and urine albumin-to-creatinine ratio ≥100 mg/g with eGFR 30–90 mL/1.73 m^2 on a renin-angiotensin-aldosterone system (RAS) inhibitor.

Recommendation 11.10 was revised to clarify guidance on kidney-protective medications that are potentially harmful in pregnant and sexually active individuals of childbearing potential.

Recommendation 11.11a was added to address SGLT2 inhibitor use in individuals who are not on dialysis to reduce the risk of CKD progression and for cardiovascular benefits.

Recommendation 11.11b was added to provide guidance on initiation or continuation of GLP-1–based therapy in individuals on dialysis to reduce cardiovascular risk.

Figure 11.2 was modified to reorder the placement of the RAS inhibitor dose to reflect that the majority of the participants in kidney outcome trials investigating SGLT2 inhibitors, GLP-1 RAs, and nsMRAs were receiving background optimized RAS inhibitor therapy.

12. Retinopathy, Neuropathy, and Foot Care

(https://doi.org/10.2337/dc26-S012)

A new introduction has been added to provide appropriate pathophysiological context for the subsections, including discussion of the 40-year Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications (DCCT/EDIC) study results.

The narrative was expanded to discuss the effect of GLP-1 RA treatment on eye health, including nonarteritic anterior ischemic optic neuropathy, glaucoma, neovascular age-related macular degeneration, and diabetic retinopathy progression.

The role of adjunctive therapies was broadened to emphasize a holistic, multifactorial approach to eye health in diabetes.

Neuropathy diagnosis discussion was updated to align more closely with the "Foot Care" subsection, incorporating the Ipswich touch test.

Recommendation 12.22 was updated to emphasize the importance of combination therapy for additional relief of neuropathic pain.

The narrative was strengthened regarding prevention and management of diabetic foot complications. In this regard, the importance of infection and its prompt management was added throughout the text.

Emerging technologies in foot care are now discussed, including self-monitoring of foot temperatures using smart mats, insoles, or socks for early identification of impending ulceration.

The importance of adjunctive advanced therapies was emphasized, particularly for diabetic foot ulcers unresponsive to standard care or surgical care. Discussion of the Wound Ischemia foot Infection (WIfI) staging system for diabetic foot lesions was expanded; it is now described as increasingly used to stage peripheral artery disease severity, predict diabetic foot ulcer healing, and assess amputation risk.

The narrative was updated to highlight the need for holistic and interventional approaches in managing diabetes with peripheral artery disease. Emerging evidence was added for GLP-1 RA therapies, which may reduce lower-extremity amputations.

13. Older Adults

(https://doi.org/10.2337/dc26-S013)

In the "Hypoglycemia" section, Recommendation 13.5 now recommends use of CGM for older adults with type 1 diabetes or type 2 diabetes on insulin to improve glycemic outcomes, reduce hypoglycemia, and reduce treatment burden.

In "Treatment Goals," Recommendation 13.9 now provides a more specific on-treatment blood pressure goal for most older adults of <130/80 mmHg when it can be achieved safely and a more relaxed blood pressure goal (e.g., <140/90 mmHg) for people with poor health, limited life expectancy, or high risk for adverse effects of hypertensive therapy.

In the "Lifestyle Management" section, Recommendation 13.11a now includes more specific guidance on protein intake (at least 0.8 g/kg body weight/day).

In the "Lifestyle Management" section, Recommendation 13.11b is now a separate recommendation for types of exercise and physical activity to maintain lean body mass, especially in those pursuing intentional weight loss.

Terminology for care in nursing home and assisted living settings was standardized by using the term post-acute and long-term care (PALTC).

Table 13.1 has been introduced to provide specific guidance for assessing older adults with diabetes for geriatric syndromes and other functional impairments using sample screening questions and validated languages.

Figure 13.2 has been introduced to illustrate a stepwise approach for assessing difficulties in the diabetes treatment plan; reevaluating glycemic goals through shared decision-making; deintensifying, simplifying, or modifying the treatment plan; and reassessing the safety and burdens of any interventions.

14. Children and Adolescents

(https://doi.org/10.2337/dc26-S014)

Section 14 was reorganized to clearly differentiate guidance for type 1 versus type 2 diabetes in children and adolescents while merging sections that applied to both types of diabetes in children and adolescents.

Narrative discussions of developmental considerations and the impact of obesity and psychosocial factors were expanded.

Language in Recommendation 14.1 was strengthened to emphasize child and family-centered care, ongoing reassessment of self-care transfer, and training of daycare and school personnel.

Recommendation 14.2 was modified to reinforce comprehensive nutrition education at diagnosis and annually, tailored to growth, eating patterns, and risk factors.

Recommendation 14.3 was expanded to include evidence on macronutrient composition (carbohydrate, fat, and protein) and its impact on insulin dosing, glycemic excursions, and long-term outcomes.

The "Physical Activity and Exercise" section recommendations now emphasize ≥60 min/day of moderate-to-vigorous activity, with bone- and muscle-strengthening activities ≥3 times/week. New guidance on strategies to prevent exercise-related hypoglycemia and hyperglycemia and importance of treatment availability during activity was added.

The "Psychosocial Care" section was updated to include behavioral health professionals as integral team members; routine screening for food insecurity, housing stability, literacy, and social support; confidential time for adolescents with providers at developmentally appropriate ages; screening for diabetes distress, depression, anxiety, fear of hypoglycemia, and disordered eating behaviors starting as early as age 7–8 years; and collaboration with behavioral health providers for individualized interventions (e.g., cognitive behavioral therapy and mindfulness-based approaches).

Table 14.1 was added to provide easier comparison of type 1 and type 2 diabetes recommendations. **Table 14.1** and text were updated to reflect the current evidence on lipid screening, microalbuminuria, retinopathy, and neuropathy in children and adolescents. New evidence from SEARCH for Diabetes in Youth (SEARCH), Treatment Options for Type 2 Diabetes in Adolescents and Youth (TODAY), and T1D Exchange studies was incorporated to refine timing and frequency of screening.

Recommendation language around use of CGM, artificial intelligence–based retinal screening tools, and pharmacotherapies (i.e., GLP-1 RAs, SGLT2 inhibitors, and a dual GIP and GLP-1 RA) was added.

In the "Type 2 Diabetes in Children and Adolescents" section, new pharmacotherapy data for GLP-1 RAs, SGLT2 inhibitors, and the dual GIP and GLP-1 RA and their U.S. Food and Drug Administration approval status in the pediatric population were added with up-to-date randomized controlled trial discussion, and discussion of metabolic and bariatric surgery outcomes was expanded with ≥10-year follow-up data.

Recommendations and references in the section "Transition From Pediatric to Adult Care for All Children and Adolescents With Diabetes" were updated to emphasize structured transition programs, improved clinic attendance, and digital tools to support continuity of care.

15. Management of Diabetes in Pregnancy

(https://doi.org/10.2337/dc26-S015)

Recommendation 15.3 was modified to emphasize that preconception counseling should include the importance of avoiding excessive hypoglycemia in achieving preconception glycemic goals.

The narrative sections "Preconception Counseling" and "Preconception Care" were reorganized, including consolidation of the counseling pertinent to weight management.

The narrative text was updated to include preconception glucose goals (in addition to the preconception A1C goal) to guide therapeutic adjustments.

The narrative text was updated to provide guidance regarding preconception discontinuation of GLP-1 RA and dual GIP and GLP-1 RA therapy and to emphasize that preconception glycemic goals should be achieved following discontinuation of GLP-1 RA or dual GIP and GLP-1 RA therapy before attempting conception.

The narrative text regarding early abnormal glucose metabolism was moved from section 2, "Diagnosis and Classification of Diabetes," to the present section and updated to include recent evidence and controversies regarding optimal management strategies.

The narrative text was updated to include recent randomized controlled trials evaluating CGM use in gestational diabetes mellitus.

The narrative text was updated to provide additional information regarding use of currently available insulin preparations during pregnancy.

The narrative text subsections regarding CGM use in pregnancy and AID use in pregnancy that were previously included in both section 7, "Diabetes Technology," and section 15, "Management of Diabetes in Pregnancy," were consolidated and are now found in the present section only.

Recommendation 15.24 was modified to use the blood pressure threshold of 140/90 mmHg for initiation or titration of antihypertensive therapy, for both clarity and alignment with recent randomized controlled trial data.

Recommendation 15.25b was updated to include severe hypertriglyceridemia as an additional factor that may in some circumstances warrant continued use of lipid-lowering therapy during pregnancy.

The narrative text was updated to state that, in a small subset of individuals who are unable to tolerate or decline the postpartum OGTT, an A1C performed at 6–12 months postpartum may be considered as supplementary diagnostic information, noting that it should

not replace the gold standard postpartum OGTT.

16. Diabetes Care in the Hospital
(https://doi.org/10.2337/dc26-S016)
Two new recommendations were added for glycemic goals in the perioperative period. To improve postoperative outcomes, Recommendation 16.14 suggests an A1C goal <8% (<64 mmol/mol) within 3 months of elective surgery. Alternatively, a 14-day glucose management indicator goal <8% or time in range >50% can also be used. Recommendation 16.15 was added to advise a blood glucose range 100–180 mg/dL (5.6–10.0 mmol/L) during the perioperative period.

For individuals with diabetes not being discharged to their home, Recommendation 16.18 was updated to suggest considering the capabilities of the facility for diabetes management.

Tables 16.1 and **16.2** were included to provide information on diagnostic criteria and clinical presentation for diabetic ketoacidosis and hyperglycemic hyperosmolar state.

The narrative text was updated to expand upon technology use in the hospital setting and noninsulin therapies in the perioperative period.

17. Diabetes Advocacy
(https://doi.org/10.2337/dc26-S017)
No revisions have been made for the 2026 Standards of Care.

Introduction and Methodology: Standards of Care in Diabetes—2026

*American Diabetes Association Professional Practice Committee for Diabetes**

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Diabetes is a complex, chronic condition requiring continuous care with comprehensive risk-reduction strategies beyond glycemic management. Ongoing diabetes self-management education and support are critical to empowering people, preventing acute complications, and reducing the risk of long-term complications. Significant evidence exists that supports a range of interventions to improve diabetes outcomes.

The American Diabetes Association (ADA) "Standards of Care in Diabetes," referred to here as the Standards of Care, serves as a comprehensive resource to clinicians, researchers, policymakers, and other stakeholders. It outlines key elements of diabetes care, sets treatment goals, and provides tools to assess care quality, all directed at improving diabetes care and outcomes across diverse populations.

The ADA Professional Practice Committee for Diabetes (PPC) updates the Standards of Care annually. Discussion of emerging clinical considerations is included in the text, and, as evidence evolves, clinical guidance is updated within the recommendations. The Standards of Care is a "living" document where important updates are published online should the PPC determine that new evidence or regulatory changes (e.g., medication or technology approvals, label changes) merit immediate inclusion. More information on the living standards can be found on the ADA professional website Diabetes Pro at professional.diabetes.org/standards-of-care/living-standards-update. The Standards of Care supersedes all previously published ADA scientific documents—and the guidance therein—on clinical topics within the purview of the Standards of Care.

The Standards of Care is internally reviewed by the ADA Medical Affairs scientific team for methodological rigor, accuracy, clarity, and implementation; the Standards of Care then undergoes external peer review, ADA leadership review, and ADA Board of Directors review and approval.

SCOPE OF THE GUIDELINES

The recommendations in the Standards of Care include screening, diagnostic, and therapeutic actions that are scientifically proved or known based on expert clinical practice or believed to favorably affect health outcomes of people with diabetes. They also cover the prevention, screening, diagnosis, and management of diabetes-associated complications and comorbidities. The recommendations encompass care throughout the life span for children (aged birth to 11 years), adolescents (aged 12–17 years), adults (aged 18–64 years), and older adults (aged ≥65 years). The recommendations cover the management of type 1 diabetes, type 2 diabetes, gestational diabetes mellitus, and other types of diabetes and/or hyperglycemic conditions.

The Standards of Care does not provide comprehensive treatment plans for complications associated with diabetes, such as diabetic retinopathy or diabetic foot ulcers, but offers guidance on how and when to screen for diabetes complications, management of complications in the primary care and diabetes care settings, and referral to specialists as appropriate. Similarly, regarding the psychosocial and behavioral health factors often associated with diabetes and that can affect diabetes care, the Standards of Care provides guidance on how and when to screen, management in the primary care and diabetes care settings, and referral but does not provide comprehensive management plans for conditions that require specialized care, such as mental illness.

INTENDED AUDIENCE

The intended audience for the Standards of Care includes primary care physicians, endocrinologists, nurse practitioners, physician associates/assistants, pharmacists, registered dietitian nutritionists, diabetes care and education specialists, and all members of the diabetes care team. The Standards of Care also provides guidance to specialists caring for people with diabetes and its multitude of complications, such as cardiologists, gastroenterologists,

The "Standards of Care in Diabetes," formerly called "Standards of Medical Care in Diabetes," was originally approved in 1988 and published in 1989. The most recent full review and revision was in December 2025.

**A complete list of members of the American Diabetes Association Professional Practice Committee for Diabetes is provided in this section.*

Duality of interest information for each contributor is available at https://doi.org/10.2337/dc26-SDIS.

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nephrologists, emergency physicians, internists, pediatricians, psychologists, neurologists, ophthalmologists, and podiatrists. Additionally, these recommendations help payors, policymakers, researchers, research funding organizations, and advocacy groups align their policies and resources and deliver optimal care for people living with diabetes. A consumer-facing plain language summary of the Standards of Care for people with diabetes can be found at diabetesjournals.org/clinical/article/43/3/335/160650/Your-Rights-and-Care-Standards-A-Guide-for-People.

The ADA strives to improve and update the Standards of Care to ensure that clinicians, health plans, and policymakers can continue to rely on it as the most authoritative source for current guidelines for diabetes care. The Standards of Care recommendations are not intended to preclude clinical judgment. They must be applied in the setting and context of excellent clinical care, with adjustments for individual preferences, comorbidities, and other person-specific factors. For more detailed information about the management of diabetes, please refer to *Medical Management of Type 1 Diabetes* (1) and *Medical Management of Type 2 Diabetes* (2).

METHODOLOGY AND PROCEDURE

The Standards of Care includes discussion of evidence and clinical practice recommendations intended to optimize care for people with diabetes by assisting health care professionals and individuals in making shared decisions about diabetes care. These recommendations are based on a comprehensive evaluation of the available evidence, along with a careful assessment of the benefits and risks associated with different care strategies.

Professional Practice Committee for Diabetes

The diabetes PPC of the ADA is responsible for the Standards of Care content. The PPC is an interprofessional expert committee comprising physicians, nurse practitioners, pharmacists, diabetes care and education specialists, registered dietitian nutritionists, behavioral health scientists, and others who have expertise in a range of areas including but not limited to adult and pediatric endocrinology, epidemiology, public health, behavioral health, cardiovascular risk management, microvascular complications, nephrology, neurology, ophthalmology, podiatry, clinical pharmacology, preconception and pregnancy care, weight management and obesity treatment, diabetes prevention, and use of technology in diabetes management. Each year, ADA conducts a national call for applications to recruit members of the PPC. Appointment to the PPC is based on excellence in clinical practice and research, with attention to appropriate representation of members based on considerations including but not limited to demographic, geographic, work setting, or identity characteristics (e.g., gender, race and ethnicity, ability level). A PPC chair or co-chairs are appointed by the ADA (M.B. and R.G.M. are co-chairs for the 2026 Standards of Care) and oversee the committee. In addition to the PPC members, several professionals serve as designated subject matter experts to support the PPC in the development of specific content areas of the Standards of Care. While designated subject matter experts assist with content development, only PPC members formally vote on Standards of Care recommendations for final approval.

Additionally, several organizations have endorsed specific sections of the 2026 Standards of Care. The American Society for Bone and Mineral Research (ASBMR) reviewed and approved the "Bone Health" subsection in section 4, "Comprehensive Medical Evaluation and Assessment of Comorbidities." The Obesity Society (TOS) reviewed and approved section 8, "Obesity and Weight Management for the Prevention and Treatment of Diabetes." The American College of Cardiology (ACC) reviewed and approved section 10, "Cardiovascular Disease and Risk Management." The American Geriatrics Society (AGS) reviewed and approved section 13, "Older Adults." New to the 2026 Standards of Care, the National Kidney Foundation (NKF) reviewed and approved section 11, "Chronic Kidney Disease and Risk Management," and the International Society for Pediatric and Adolescent Diabetes (ISPAD) reviewed and approved section 14, "Children and Adolescents."

Each section of the Standards of Care is reviewed annually and updated with the latest evidence-based recommendations by a subcommittee. The subcommittees perform systematic literature reviews to identify and summarize the latest scientific evidence. An information specialist with knowledge and experience in literature searching (a librarian) is consulted as necessary. A guideline methodologist (R.R.B. for the 2026 Standards of Care) with expertise and training in evidence-based medicine and guideline development methodology oversees all methodological aspects of the development of the Standards of Care and serves as a statistical analyst.

Disclosure and Duality of Interest Management

All members of the PPC, subject matter experts, and the ADA scientific team are required to comply with the ADA policy on duality of interest, which requires disclosure of any financial, intellectual, or other interests that might be construed as constituting an actual, potential, or apparent conflict, regardless of relevancy to the guideline topic. For transparency, ADA requires full disclosure of all relationships. Full disclosure statements from all committee members are solicited and reviewed during the appointment process. Disclosures are then updated throughout the guideline development process (specifically before the start of every meeting), and disclosure statements are submitted by every Standards of Care contributor upon submission of the updated Standards of Care section. Members are required to disclose conflicts for a time frame that includes 1 year prior to initiation of the committee appointment process until publication of that year's Standards of Care. Potential dualities of interest are evaluated by a panel of experts and, if necessary, the Legal Affairs Division of the ADA. The duality of interest assessment is based on the relative weight of the financial relationship (i.e., the monetary amount) and the relevance of the relationship (i.e., the degree to which an independent observer might reasonably interpret an association as related to the topic or recommendation of consideration). In addition, the ADA adheres to section 7 of the Council of Medical Specialty Societies "Code for Interactions with Companies" (3). The ADA also ensures the majority of the PPC and the PPC chair or co-chairs are without potential conflict relevant to the subject area. Furthermore, the PPC chair or co-chairs are required to remain unconflicted for 1 year after the publication of the Standards of Care. Members of the committee who disclose a potential duality of interest pertinent to any specific recommendation are prohibited from voting or their votes are excluded. No PPC members or subject matter experts were employees of any pharmaceutical or medical

device company during the development of the 2026 Standards of Care. Members of the PPC and subject matter experts, their employers, and their disclosed potential dualities of interest are listed in the section "Disclosures: Standards of Care in Diabetes—2026."

Funding Source

The Standards of Care guideline is funded by ADA general revenue. No other entity, including industry, provides financial support for the guideline. Committee members received no remuneration for their participation in the development of this guideline.

Evidence Review

The Standards of Care subcommittee for each section creates an initial list of relevant clinical questions that is reviewed and discussed by the PPC. In consultation with a systematic review expert and librarian, each subcommittee devises and executes systematic literature searches. For the 2026 Standards of Care, PubMed, Medline, and EMBASE were searched for the time periods of 1 June 2024 to 18 July 2025. Searches are limited to studies published in English. Subcommittee members also manually search journals, reference lists of conference proceedings, and regulatory agency websites. All potentially relevant citations are then subjected to a full-text review. In consultation with the methodologist, the subcommittees prepare the evidence summaries and grading for each section of the Standards of Care. All PPC members discuss and review the evidence summaries and make revisions as appropriate. The final evidence summaries are then deliberated on by the PPC, and the recommendations that will appear in the Standards of Care are drafted.

Grading of Evidence and Recommendation Development

A grading system (**Table 1**) developed by the ADA and modeled after existing methods is used to clarify and codify the evidence that forms the basis for the recommendations in the Standards of Care. All recommendations in the Standards of Care are critical to comprehensive care regardless of rating. ADA recommendations are assigned ratings of **A**, **B**, or **C**, depending on the quality of the evidence in support of the recommendation. Expert opinion **E** is a separate category for recommendations for which there is no evidence from clinical trials, clinical trials may be impractical, or there is conflicting evidence. Recommendations assigned an **E** level of evidence are informed by key opinion leaders in diabetes (members of the PPC and subject matter experts) and cover important elements of clinical care. All Standards of Care recommendations receive a rating for the strength of the evidence and not for the strength of the recommendation. Recommendations with **A**-level evidence are based on large, well-designed randomized controlled trials or well-done meta-analyses of randomized controlled trials. Generally, these recommendations have the best chance of improving outcomes when applied to the population for which they are appropriate. Recommendations with lower levels of evidence may be equally important but are not as well supported by the evidence.

Of course, published evidence is only one component of clinical decision-making. Clinicians care for people, not populations; guidelines must always be interpreted with the individual person in mind. Individual circumstances, such as comorbid and coexisting diseases, age, education, disability, and, above all, the values and preferences of the person with diabetes, must be considered and may lead to different treatment goals and strategies. Furthermore, conventional evidence hierarchies, such as the one adapted by the ADA, may miss nuances important in diabetes care. For example, although there is excellent evidence from clinical trials supporting the importance of achieving multiple risk factor control, the optimal way to achieve this result is less clear. It is difficult to assess each component of such a complex intervention.

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

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

Evidence to Recommendations

All accumulated evidence was reviewed and discussed by all PPC members and subject matter experts during multiple virtual meetings and a 2-day in-person meeting in Arlington, Virginia, in July 2025. Standards of Care recommendations were updated based on the newly acquired evidence, and each recommendation was voted on by the PPC, with 80% consensus required for any recommendation to be approved.

Revision Process

Public comment is particularly important in the development of clinical practice recommendations; it promotes transparency and provides key stakeholders,

including people with diabetes and their caregivers, the opportunity to identify and address gaps in care. The ADA holds a year-long public comment period requesting feedback on the Standards of Care. The PPC reviews all compiled feedback from the public in preparation for the annual update but considers more pressing updates throughout the year, which may be published as living standards updates. Feedback from the larger clinical community and general public was invaluable for the revision of the 2025 Standards of Care. Readers who wish to comment on the 2026 Standards of Care are invited to do so at professional.diabetes.org/SOC.

Feedback for the Standards of Care is also obtained from external peer reviewers and from the aforementioned endorsing societies (ACC, AGS, ASBMR, ISPAD, NKF, and TOS). The Standards of Care is reviewed by the ADA Medical Affairs scientific team for methodological rigor, accuracy, clarity, and implementation; the Standards of Care then undergoes external peer review, ADA leadership review, and ADA Board of Directors review and approval (this includes review by health care professionals, scientists, and other stakeholders). Feedback received from every stakeholder is adequately addressed by the committee, and the final version is approved by all parties prior to publication. The ADA adheres to the Council of Medical Specialty Societies revised "CMSS Principles for the Development of Specialty Society Clinical Guidelines" (4).

ADA GUIDANCE CATEGORIES

The ADA has been actively involved in developing and disseminating diabetes care clinical practice recommendations and related documents for more than 35 years. The ADA Standards of Care is an essential resource for health care professionals caring for people with diabetes. ADA Statements, Consensus Reports, and Scientific Reviews support the recommendations included in the Standards of Care.

Standards of Care

The annual Standards of Care supplement to the *Diabetes Care* journal contains the official ADA position, is authored by the ADA under the guidance of the PPC, and provides all the ADA's current clinical practice recommendations.

Consensus Report

An ADA consensus report is a document on a particular topic that is authored by a technical expert panel under the auspices of ADA. The document does not reflect the official ADA position but rather represents the panel's collective analysis, evaluation, and expert opinion. The primary objective of a consensus report is to provide clarity and insight on a medical or scientific matter related to diabetes for which the evidence is contradictory, emerging, or incomplete. The report also aims to highlight evidence gaps and to propose avenues for future research. Consensus reports undergo a formal review process, including external peer review and review by the ADA PPC and ADA scientific team, for publication.

When participating in a joint consensus report, ADA, in collaboration with the partner organization, designates representatives who will be involved in all phases of consensus report development (i.e., from initiation through publication). Similar to an ADA consensus report, the joint consensus report is intended to highlight an emerging area in diabetes care, follows the same rigorous review procedures, and does not reflect the official ADA position.

Scientific Review

A scientific review is a balanced systematic review and analysis of literature on a scientific or medical topic related to diabetes. A scientific review is not an ADA position and does not contain clinical practice recommendations but is produced under the auspices of the ADA by invited experts. The scientific review may provide a scientific rationale for clinical practice recommendations in the Standards of Care. The category may also include task force and expert committee reports.

ADA Statement

An ADA statement is an ADA point of view or position that does not contain clinical practice recommendations and may be issued on advocacy, policy, economic, or medical issues related to diabetes. ADA statements undergo a formal review process, including external peer review and review by the ADA Professional Practice Committee for Diabetes, ADA clinical leadership, ADA scientific team, and, as warranted, the ADA Board of Directors.

ADA ENDORSEMENT PROCESS

Endorsement by ADA signifies formal support for a scientific document, such as a clinical guideline or consensus report. The endorsement process involves a thorough review by the PPC for alignment with ADA's mission, the Standards of Care, and evidence-based principles. The endorsement indicates that the content is scientifically accurate, relevant, and valuable to health care professionals caring for people with diabetes. While endorsement conveys support for the scientific concepts, it may not extend to every specific statement or phrasing. Although ADA representatives are generally involved throughout the development of these documents, ADA endorsement does not reflect the official ADA position. The type and level of ADA endorsement may vary based on the type of document and the extent of ADA involvement in the development process.

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