



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 associatesassistants, 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 [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* \(2\).](https://diabetesjournals.org/clinical/article/43/3/335/160650>Your-Rights-and-Care-Standards-A-Guide-for-People.</p></div><div data-bbox=)

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.

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,

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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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

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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