Standards of Care in Diabetes – Highlights from the ADA Standards and AACE T2D Consensus Algorithm

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Disclosure

Consultant: Genentech/Roche

Independent Data Monitoring Committee: Genentech/Roche

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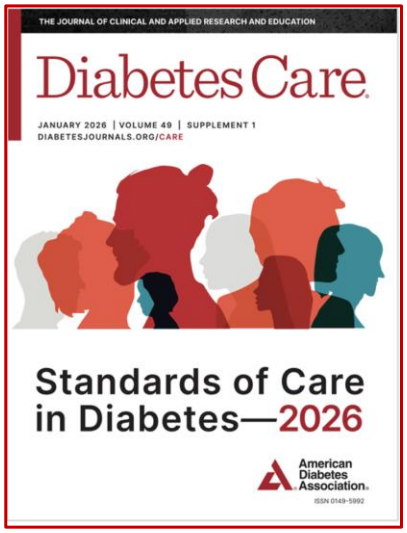
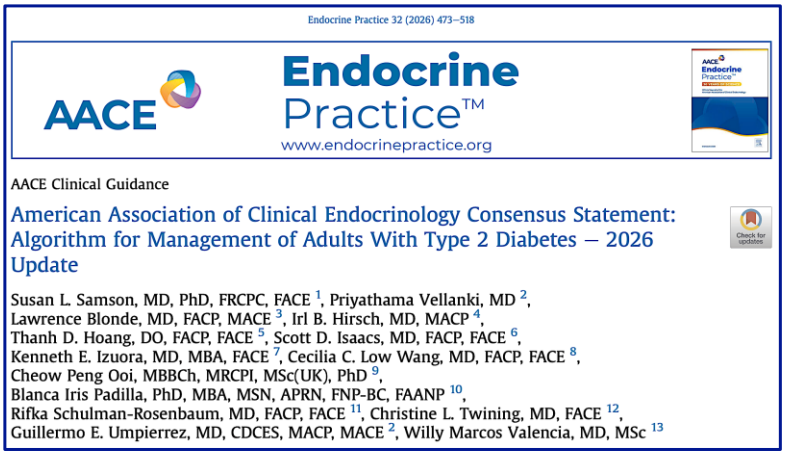


American Diabetes Association



American Association of Clinical Endocrinology

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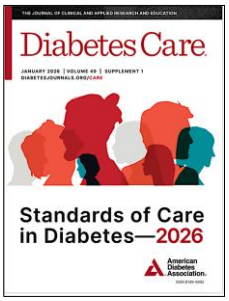
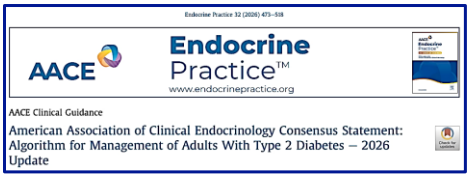
Highlights for Diabetes in 2026

- Classifying prediabetes – beyond type 2 diabetes
- Diabetes technology – the earlier the better
- Blood pressure goals
- Lipid management
- Glucose-lowering medications overview
- Diabetes and osteoporosis
- New diagnostic criteria for DKA
- Perioperative glycemic goals





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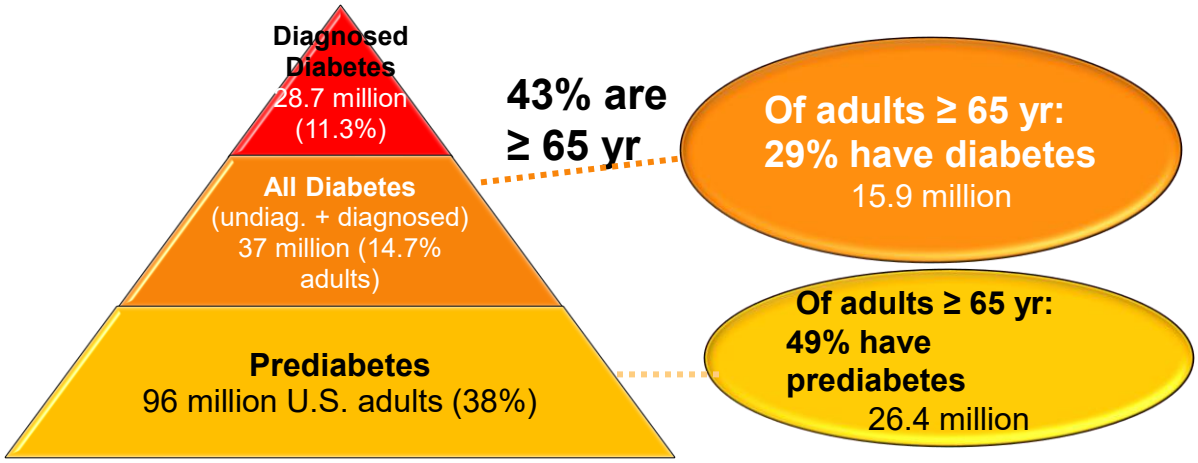
The Prevalence of Diabetes in US Adults Is Very High



https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-undiagnosed-diabetes.html

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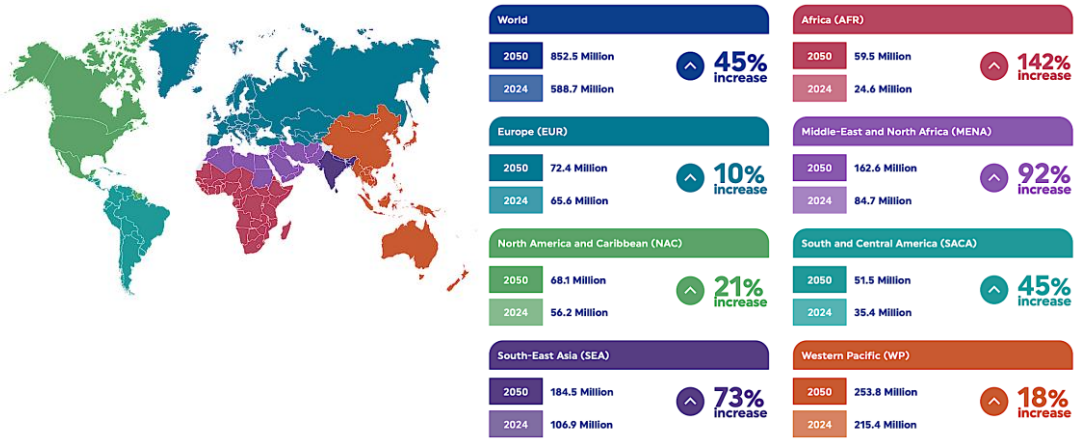
The Prevalence of Diabetes Is Predicted to Continue to Increase Worldwide



IDF Diabetes Atlas 11th Edition - 2025 | diabetesatlas.org

6

Paradigm Shifts for 2026

The Historical Standard	The 2026 Paradigm Shift	Monday Morning Clinical Impact
Glucocentric (A1C reduction as primary goal).	Cardiorenal-Metabolic & Weight-Centric.	**Treating obesity and protecting organs** are equally prioritized alongside glucose control.
Reactive (Fingersticks first, CGM for complex cases).	Proactive & Universal.	**Early initiation of Continuous Glucose Monitoring (CGM) and Automated Insulin Delivery (AID) systems.**
Isolated physical metrics.	Whole-Person Care.	**Routine assessment of Social Determinants of Health (SDOH), behavioral health, and sleep chronotype.**

(1) ADA PPC. *Diabetes Care* 2026;49(Suppl. 1). (2) Samson SL, et al. *Endocr Pract* 2026;32:473-518. (3) Ndumele CE, et al. *Circ* 2023;148:1606-1635.

Graphic prepared with help of Notebook LM AI using ADA & AACE guidelines, AHA CKM advisory as reference documents.

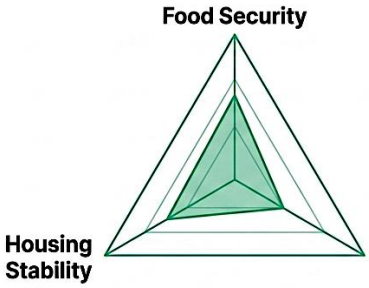
7

The Foundations: Person-Centered Care & SDOH

Language Matters

Instead of Diabetic	→	Use **Person with diabetes** (Person-first)
Instead of Non-compliant	→	Use **Facing barriers** (Strengths-based)
Instead of Good/Bad blood sugars	→	Use **In target / Out of target** (Neutral, fact-based)

The SDOH Radar



Actionable Data Point
Routinely assess for financial obstacles; consider lower-cost medications (metformin, sulfonylureas, human insulin) if costs impede evidence-based care.

(1) ADA PPC. *Diabetes Care* 2026;49(Suppl. 1). (2) Samson SL, et al. *Endocr Pract* 2026;32:473-518. (3) Ndumele CE, et al. *Circ* 2023;148:1606-1635.

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8

Classification of Prediabetes: *Beyond Type 2 Diabetes*

The Assumption: Dysglycemia = Metabolic Syndrome / Progression to Type 2 Diabetes.

Up to 40% of adults with new Type 1 diabetes are misdiagnosed as having Type 2.

Dysglycemia is not always a nonautoimmune progressive loss of beta-cell function. It can be the silent progression of autoimmune beta-cell destruction.

ADA PPC. 2. Diagnosis and Classification of Diabetes: Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S27-S49.

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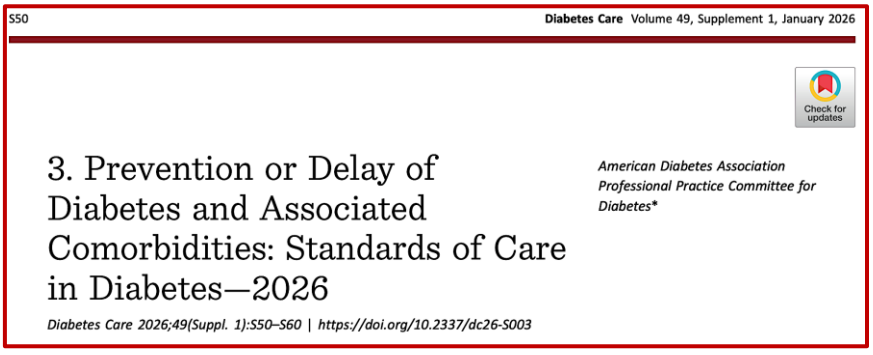

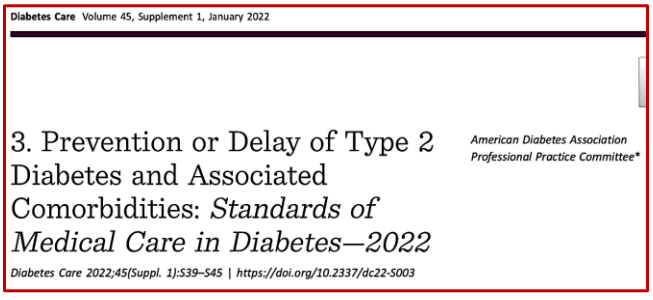

It Is Now Possible to Delay the Onset of Type 1 Diabetes in Individuals with Pre-Type 1 Diabetes/ Stage 2 T1D

Diagnosis of Pre-T1D Makes a Difference

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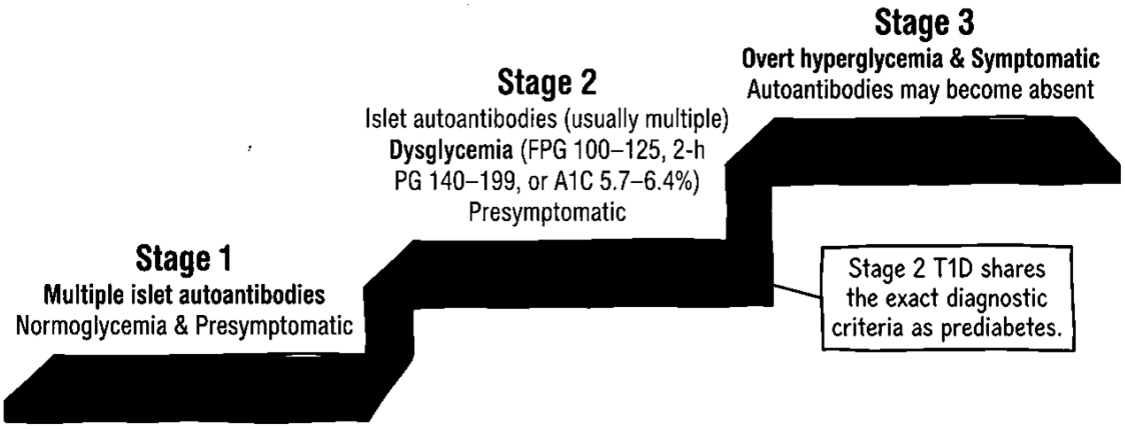
Type 1 Diabetes Has Stages Too, Including Prediabetes



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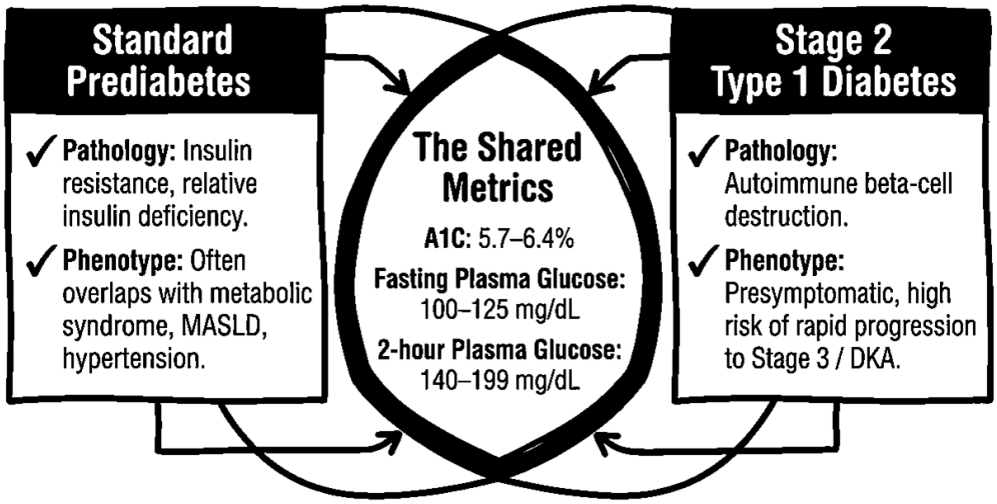
11

Diagnostic Overlap of Pre-T2-Diabetes and Pre-T1-Diabetes



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12

Why Detection of Stage 2 T1D Matters

Progression to Stage 3 (Overt T1D) is rapid.

~60% progress within 2 years.

~75% progress within 5 years.

1. **Prompt Referral:** Send to a specialized center for metabolic staging. Do not wait for overt hyperglycemia.

2. **Prevent DKA:** Educate the patient immediately on symptoms of DKA, avoiding life-threatening emergency presentations (which occur in 25-50% of undiagnosed cases).

3. **Preserve Beta Cells:** Evaluate for approved preventative treatments (e.g., teplizumab) or clinical trial enrollment to delay clinical onset.

Graphic prepared with help of Notebook LM AI using ADA standards as reference document.

ADA PPC. *Diabetes Care* 2026;49(Suppl. 1):S27-S60.

13

When to Suspect Stage 2 T1D in Prediabetes

Age — Younger age at diagnosis (specifically <35 years).

Autoimmunity — Personal or family history of autoimmune disease.

Body Habitus — Lower BMI (specifically <25 kg/m^2), lack of obesity, or unintentional weight loss.

Background — Family history of Type 1 Diabetes.

Control — Inability to achieve glycemic goals on noninsulin therapies.

Comorbidities — Treatment with immune checkpoint inhibitors (ICIs) for cancer.

ADA PPC. 2. Diagnosis and Classification of Diabetes: Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S27-S49.

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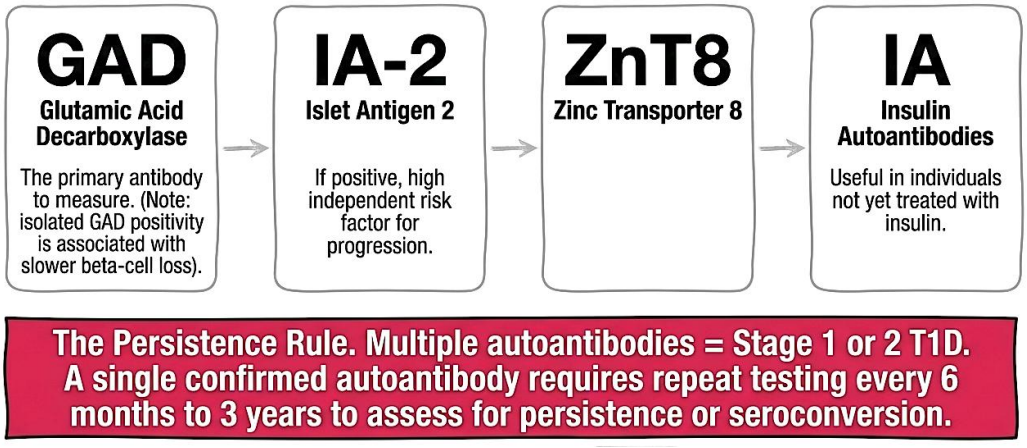
Islet Autoantibodies – The Panel



The Persistence Rule. Multiple autoantibodies = Stage 1 or 2 T1D. A single confirmed autoantibody requires repeat testing every 6 months to 3 years to assess for persistence or seroconversion.

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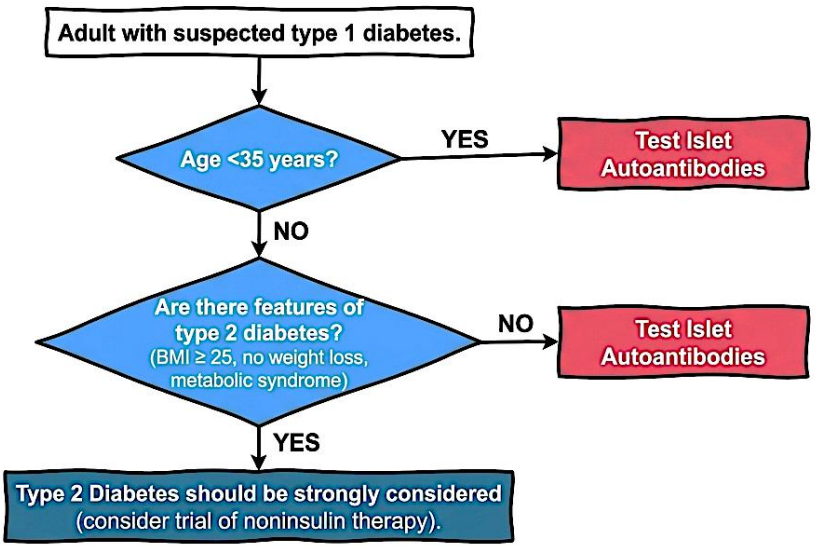
ADA PPC. *Diabetes Care* 2026;49(Suppl. 1):S27-S49.

15

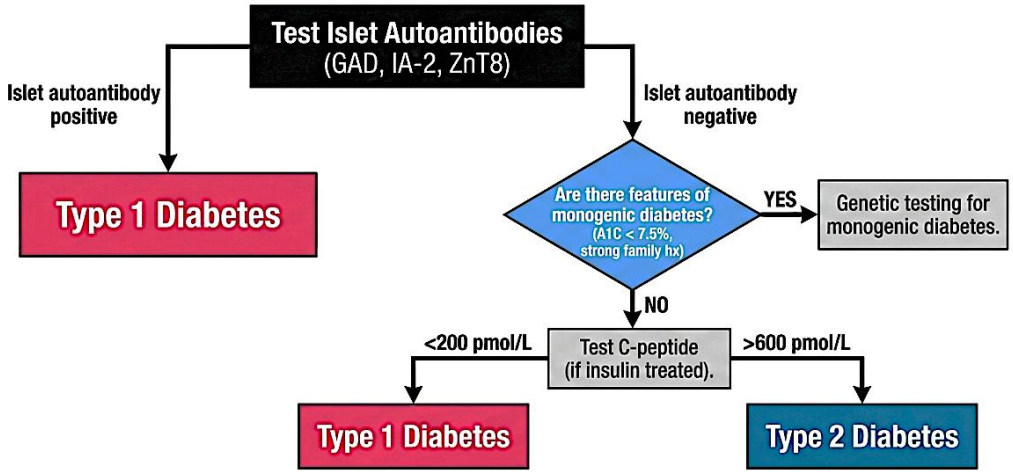
Investigating Suspected T1D in Adults - Triaging



ADA PPC. 2. Diagnosis and Classification of Diabetes: Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S27-S49.

16

Investigating Suspected T1D in Adults - Confirming

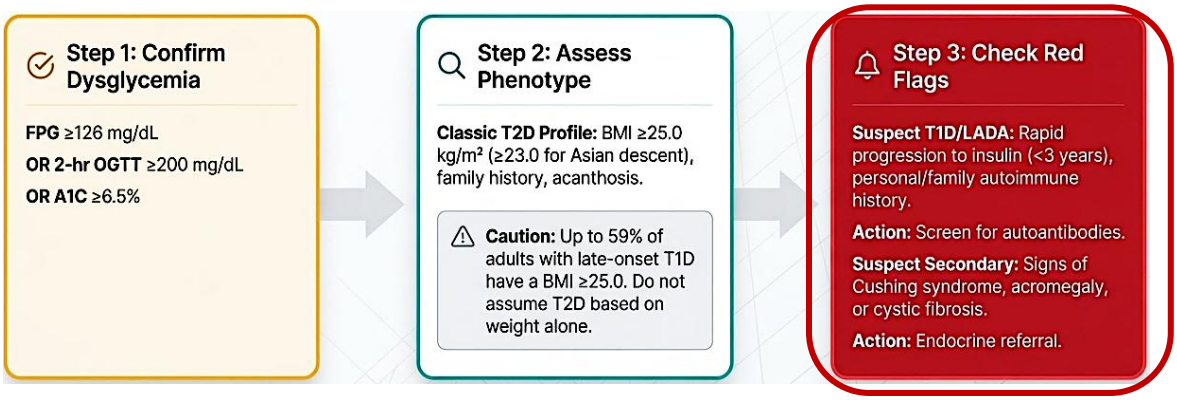


ADA PPC. *Diabetes Care* 2026;49(Suppl. 1):S27-S49.

17

Can You Be Sure It's Type 2 Diabetes?

AACE Also Has a New Algorithm for Classification This Year



Graphic prepared with help of Notebook LM AI using AACE statement as reference document.

Samson SL, et al. *Endocr Pract* 2026;32:473-518.

18

A New Paradigm for Prediabetes and Diabetes Classification in Primary Care

- ✓ Verify prediabetes/diabetes precisely using 2026 ADA criteria (confirmatory tests required).
- ✓ Do not assume all adult-onset dysglycemia is Type 2 Diabetes.
- ✓ Actively look for the AABBCC clinical flags (Age, Autoimmunity, BMI <25, Background, Control, Comorbidities).
- ✓ Screen with the Autoantibody Toolkit (GAD, IA-2, ZnT8, IA) to catch Stage 2 Type 1 Diabetes early.

Refer and intervene to preserve beta-cell function and prevent DKA before Stage 3 overt diabetes occurs, and to detect T1D

ADA PPC. 2. Diagnosis and Classification of Diabetes: Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S27-S49.
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19

2026: Diabetes Technology for All Patients with Diabetes

ADA Standards of Care for Diabetes:

- **7.1** Diabetes devices should be offered to people with diabetes. A

Principles of the AACE Algorithm for Management of Adults with Type 2 Diabetes:

- **9.** CGM is highly recommended to reach glycemic goals in adults with diabetes.

Samson SL, et al. *Endocr Pract* 2026;32:473-518.
ADA PPC. 7. Diabetes Technology - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S150-S165.

20

Available Evidence Demonstrates that C-Peptide Level Does Not Predict Efficacy of CGM

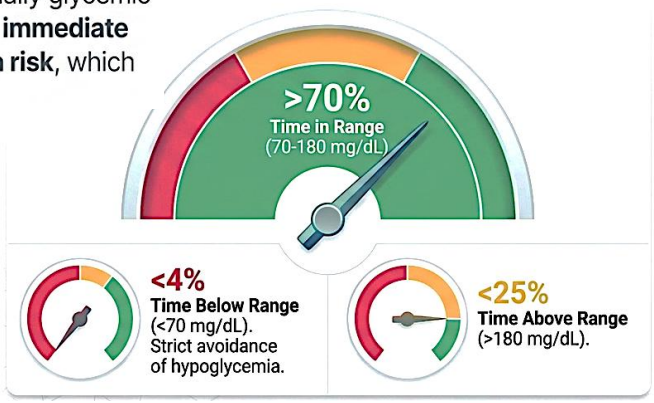
- **7.8a** There should be no requirement of C-peptide level, B the presence of islet autoantibodies, B or duration of insulin treatment C before initiation of CSII or AID.

ADA PPC. 7. Diabetes Technology - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S150-S165.

21

Modern Glycemic Targets and the CGM Dashboard

TIR captures daily glycemic variability and **immediate hypoglycemia risk**, which A1C masks.



The A1C Context

Optimal A1C is ≤6.5% only if safely achievable.

Relax to 7-8% for:
- Limited life expectancy
- Severe comorbidities
- High hypoglycemia risk
- Cognitive impairment

Every **10% increase in TIR equals an approximate 0.8% reduction in A1C.**

ADA PPC. 7. Diabetes Technology - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S150-S165.
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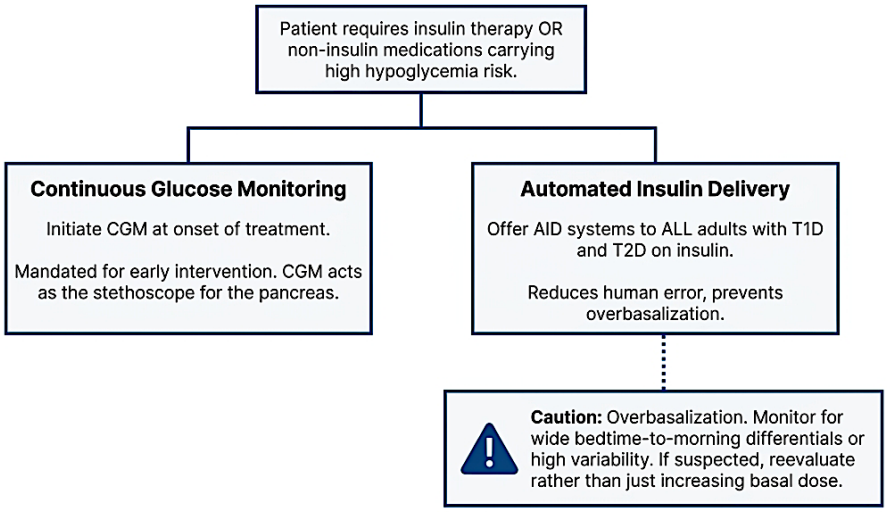
22

Diabetes Technology – Early Initiation



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23

There Is Now an Automated Insulin Delivery System (AID) FDA Approved for T2D

- **7.25a AID systems are the preferred insulin delivery method** over multiple daily injections (MDI), CSII, and sensor- augmented pump in people with type 1 diabetes, A **adults with type 2 diabetes,** A children and adolescents with type 2 diabetes, E and other forms of insulin-deficient diabetes. B–E Choice of an AID system should be made based on the individual's circumstances, preferences, and needs. E
- **7.25b Consider AID systems for select people with type 2 diabetes** treated with basal insulin not achieving individualized glycemic goals. B Choice of an AID system should be made based on the individual's circumstances, preferences, and needs. E

ADA PPC. 7. Diabetes Technology - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S150-S165.

24

AID Systems

iLet
(Beta Bionics)

Omnipod 5
(Insulet)

MiniMed 780G
(Medtronic)

T:slim X2 (Tandem)
Control IQ+

Mobi (Tandem)
Control IQ+

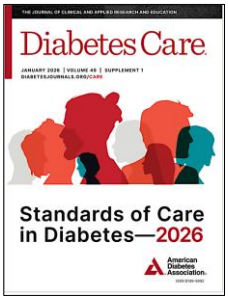
Twiist (Sequel)
Tidepool Loop

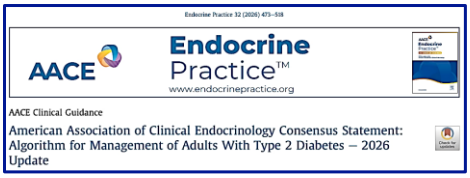
Slide from Dr. Grazia Aleppo's talk at AACE 2026 April 2026

25

Highlights for Diabetes in 2026

- Classifying prediabetes – beyond type 2 diabetes
- Diabetes technology – the earlier the better
- Blood pressure goals and management
- Lipid goals and management
- Glucose-lowering medications overview
- Diabetes and osteoporosis
- New diagnostic criteria for DKA
- Perioperative glycemic goals





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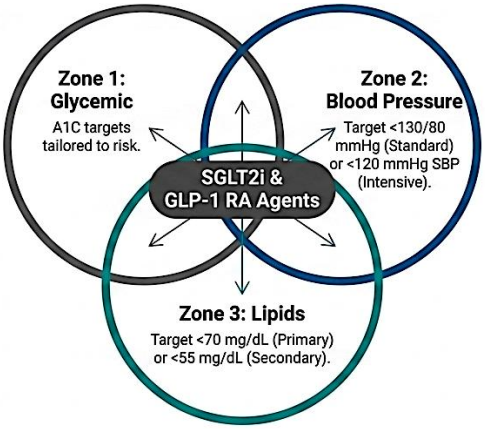
Cardiovascular Risk Reduction Needs to Include Blood Pressure, Lipids, and Meds for DM

Lifestyle Changes Are Foundational



Foundation: Lifestyle Modification & Diabetes Education.

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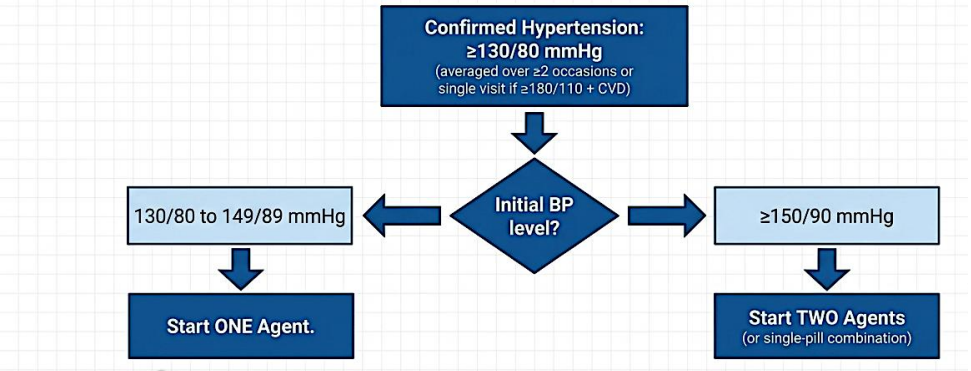
27

Starting Antihypertensive Therapies



First-Line Agent Classes with Proven CVD Benefit in Diabetes:
- ACE inhibitors (ACEi)
- Angiotensin receptor blockers (ARB)
- Thiazide-like diuretics (e.g., chlorthalidone)
- Dihydropyridine calcium channel blockers (CCB)

ADA PPC. 10. Cardiovascular Disease and Risk Management - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S216-S245.

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28

Standard vs Intensive BP Goals

<130/80 mmHg

Patient Profile: Standard risk, older adults with polypharmacy, individuals prone to orthostatic hypotension.

Clinical Rationale: Reduces cardiovascular events and microvascular complications safely for the majority.

<120 mmHg SBP

Patient Profile: High cardiovascular or kidney risk (e.g., established CVD, two or more risk factors, CKD).

Clinical Rationale: BPROAD and ESPRIT trials demonstrated a 12-21% additional reduction in major adverse cardiovascular events (MACE).

Monitoring Alert: Requires close monitoring for symptomatic hypotension, syncope, acute kidney injury (AKI), and hyperkalemia.

ADA PPC. 10. Cardiovascular Disease and Risk Management - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S216-S245.
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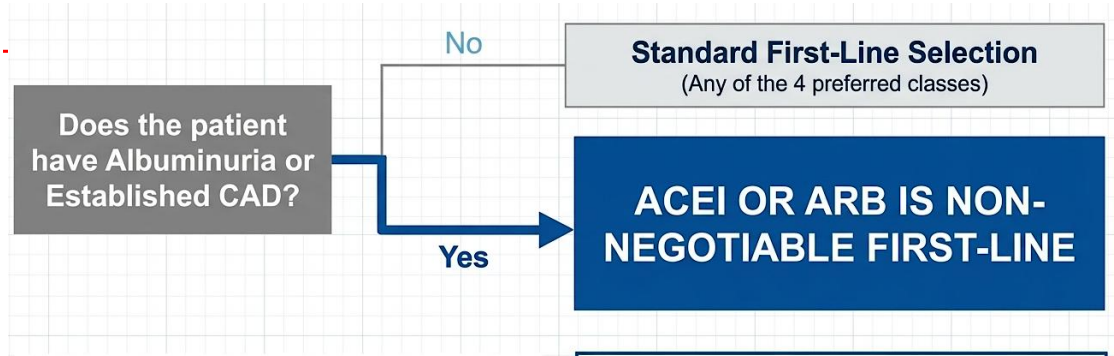
29

Albuminuria Drives 1st Line Therapy: ACEi/ARB



Zone 1. The Albuminuria Thresholds

- **UACR 30–299 mg/g**: ACEi/ARB recommended.
- **UACR ≥300 mg/g and/or eGFR <60**: ACEi/ARB strongly recommended to prevent kidney disease progression.

Zone 2. The Creatinine Caveat

Do not panic at initial creatinine rise.

Serum creatinine elevations up to 30% from baseline are expected hemodynamically. Do not discontinue ACEi/ARB unless acute kidney injury (rapid decline/volume depletion) or severe hyperkalemia occurs.

ADA PPC. 10. Cardiovascular Disease and Risk Management - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S216-S245.
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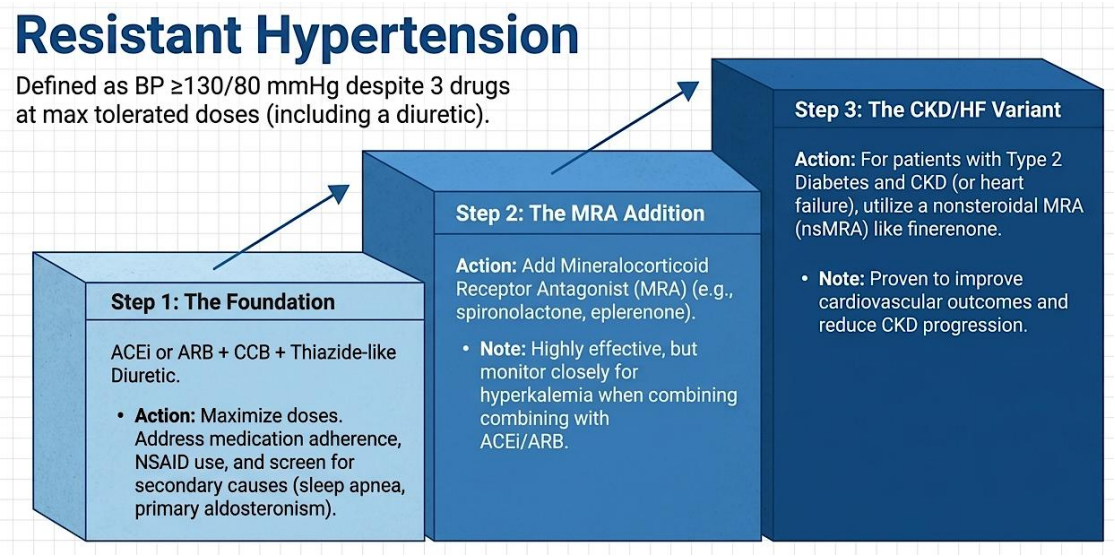

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31

Individualized BP Goals, But More Intensive in High CV or Kidney Risk; nsMRA If Resistant HTN

- **10.3** For people with diabetes and hypertension, blood pressure goals should be **individualized** through a shared decision-making process that addresses cardiovascular risk, potential adverse effects of antihypertensive medications, and individual preferences. B
- **10.4** If it can be safely attained, the on-treatment blood pressure goal is **<130/80 mmHg**; a systolic blood pressure goal **<120 mmHg** should be encouraged in individuals with high cardiovascular or kidney risk. A
- **10.13** Individuals with hypertension who are not meeting blood pressure goals on three classes of antihypertensive medications (including a diuretic) should be considered for **MRA therapy**. A

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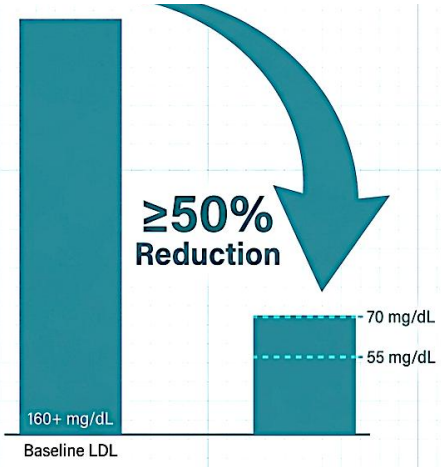
32

LDL-c Reduction Consists of Two Targets: Relative Reduction AND Absolute Level

Modern lipid management requires achieving BOTH a specific absolute threshold AND a massive relative drop from baseline.
High-intensity statins are the bridge across this chasm.



Rule 1: The Relative Drop

A ≥50% reduction in LDL cholesterol is mandated for all patients at higher cardiovascular risk or with established ASCVD.

Rule 2: The Absolute Floor

Primary Prevention (High Risk): <70 mg/dL

Secondary Prevention (ASCVD): <55 mg/dL

(1) Samson SL, et al. *Endocr Pract* 2026;32:473-518. (2) ADA PPC. 10. Cardiovascular Disease and Risk Management - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S216-S245.

Graphic prepared with help of Notebook LM AI using ADA and AACE guidelines as reference documents.

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Type 2 Diabetes Lipid Management for Primary Prevention

Age 20–39	**Condition:** + Additional ASCVD risk factors.	**Action:** Consider Moderate-Intensity Statin.
Age 40–75 (The Core Cohort)	- **Standard Risk:** Moderate-Intensity Statin. - **High Risk (≥1 ASCVD Risk Factor):** High-Intensity Statin. Target: <70 mg/dL and ≥50% reduction. - **Very High Risk** (Multiple factors + LDL ≥70): Add Ezetimibe or PCSK9i.	
Age >75	**Condition:** Already on statin -> Continue.	**Not on statin ->** Initiate moderate-intensity after risk/benefit discussion.

ASCVD risk factors: age, HTN, dyslipidemia, smoking, CKD, obesity

(1) Samson SL, et al. *Endocr Pract* 2026;32:473-518. (2) ADA PPC. 10. Cardiovascular Disease and Risk Management - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S216-S245.

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34

Type 2 Diabetes Lipid Management for Secondary Prevention: LDL-c Goal <55 mg/dL

For people of all ages with diabetes and established ASCVD, intensive therapy is non-negotiable.

<55 mg/dL

The Mandate

High-intensity statin therapy must be added to lifestyle therapy.

Target: <55 mg/dL (<1.4 mmol/L) AND ≥50% reduction from baseline.

The Adjuncts

If target is not achieved on max tolerated statin, addition of Ezetimibe or a PCSK9 inhibitor is recommended.

The Extremes

For ASCVD in multiple vascular beds (or 1 bed + age >65), consider adding low-dose Rivaroxaban (2.5 mg twice daily) + Aspirin (81 mg) if low bleeding risk.

(1) Samson SL, et al. *Endocr Pract* 2026;32:473-518. (2) ADA PPC. 10. Cardiovascular Disease and Risk Management - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S216-S245.

Graphic prepared with help of Notebook LM AI using ADA and AACE guidelines as reference documents.

35

Handling Statin Intolerance in Type 2 Diabetes

Step 1: Maximum Tolerated Statin

High-Intensity (Atorvastatin 40-80mg, Rosuvastatin 20-40mg).

If partial intolerance: Switch statins, lower dose, or try non-daily dosing.

Step 2: Ezetimibe

First-line adjunct.

First-line adjunct. Reduces LDL by an additional ~20%.

Step 3: PCSK9 Inhibitors

Monoclonal antibodies (Alirocumab, Evolocumab) or siRNA (Inclisiran). Massive further reductions (~60%).

DETOUR

The Intolerance Detour:

If complete statin intolerance: Use Bempedoic Acid (avoids skeletal muscle adverse effects) or PCSK9i. Both are proven to reduce cardiovascular event rates as alternative cholesterol-lowering plans.

(1) Samson SL, et al. *Endocr Pract* 2026;32:473-518. (2) ADA PPC. 10. Cardiovascular Disease and Risk Management - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S216-S245.

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36

Triglyceride-Lowering

Level 1: >150 mg/dL (Fasting)
Intervention: Intensive lifestyle therapy, weight loss, glycemic optimization. Address secondary factors (hypothyroidism, CKD, medications).

Level 2: 150 – 499 mg/dL + ASCVD Risk
Intervention: Add Icosapent Ethyl to statin therapy.
Rationale: REDUCE-IT trial showed 25% relative risk reduction in MACE. (Note: Benefit is specific to icosapent ethyl, do not extrapolate to generic n-3 fatty acid supplements).

Level 3: ≥500 mg/dL (Severe)
Intervention: Pharmacologic therapy (fibric acid derivatives / fish oil) + severe fat restriction.
Rationale: Primary goal shifts to mitigating the acute risk of pancreatitis. Evaluate for secondary causes.

(1) Samson SL, et al. *Endocr Pract* 2026;32:473-518. (2) ADA PPC. 10. Cardiovascular Disease and Risk Management - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S216-S245.
Graphic prepared with help of Notebook LM AI using ADA and AACE guidelines as reference documents.

37

Highlights for Diabetes in 2026

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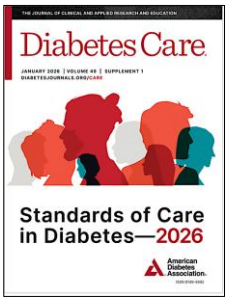
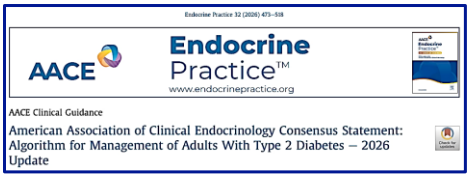




38

The Newer Diabetes Drugs

	Generic	Trade		Generic	Trade
GLP1RA	Liraglutide	Victoza (DM) Saxenda (O)	**SGLT2i**	Canagliflozin	Invokana
	Dulaglutide	Trulicity		Empagliflozin	Jardiance
	Semaglutide SQ	Ozempic (DM) Wegovy (O)		Dapaglifloxin	Farxiga
	Semaglutide PO	Rybelsus (DM) Wegovy (O)		Ertugliflozin	Steglatro
	Exenatide Qwk	Exenatide B-cise		Bexagliflozin	Brenzavvy
Basal/ GLP1RA	Glargine/ lixisenatide	Soliqua	**DPP4i**	Linagliptin	Tradjenta
	Degludec/ liraglutide	Xultophy		Sitagliptin	Januvia
GIP/GLP1 dual agonist	Tirzepatide	Mounjaro (DM) Zepbound (O)		Saxagliptin	Onglyza

39

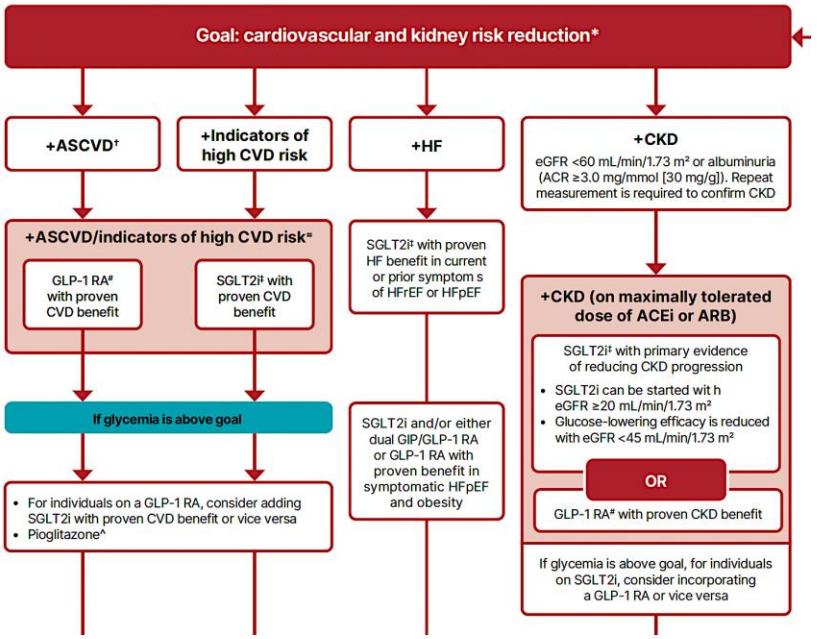
Glucose-Lowering Agents Demonstrated to Lower Cardiovascular (CV) Risk

CVOT	% with est. CVD	Median f/u (y)	MACE** (%RRR)	CV death (%RRR)	HHF (%RRR)	FDA indication for CVD?	
						2° prevention	1° prevention
Empagliflozin	99	2.6	14	38	35	✓	-
Canagliflozin	66	2.4	14	NS	33	✓	-
Dapagliflozin	40	4.2	NS	Coprimary: CV death or HHF 17%, driven by HHF		✓	✓
Liraglutide SQ	~81	3.8	13	22	NS	✓	-
Semaglutide SQ	83	2.1	26	NS	NS	✓	-
Semaglutide PO	~84	4	14	NS	(NS)	-	-
Dulaglutide SQ	31	5.4	12	NS	NS	✓	✓
Tirzepatide SQ vs dulaglutide SQ	100	4	NS vs active control	NS vs active control	-	-	-

CVOT: cardiovascular outcome trial. MACE: major adverse cardiovascular event (nonfatal MI, nonfatal stroke, CV death)

40

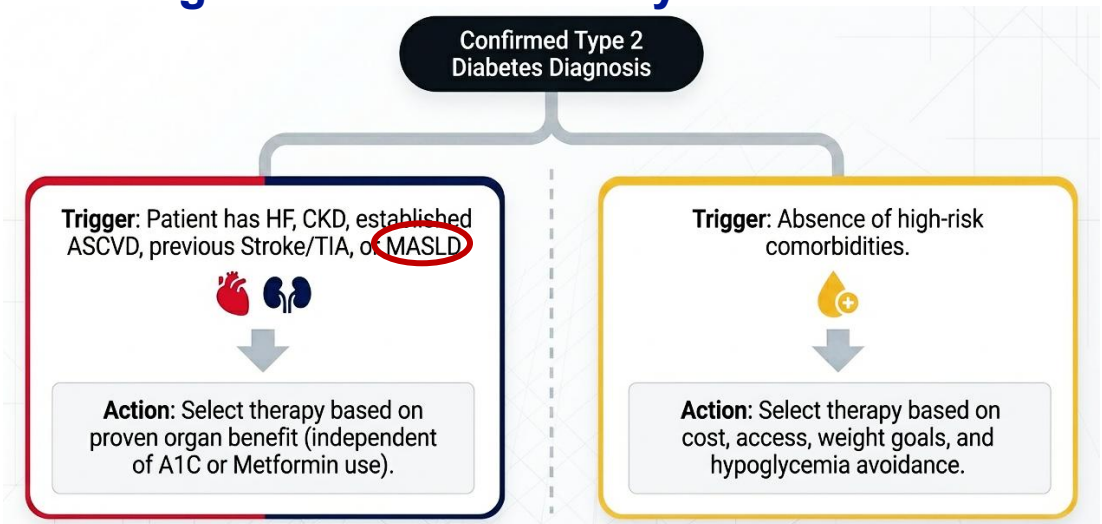
The ADA, AACE, AHA, ACC Recommend GLP1-Based Drugs and SGLT2i with Proven Benefit to Reduce Risk of ASCVD, CKD, and HF in Individuals with T2D and ASCVD, or at High Risk, CKD, and/or HF



(1) ADA PPC. *Diabetes Care* 2026;49(Suppl. 1). (2) Samson SL, et al. *Endocr Pract* 2026;32:473-518. (3) Ndumele CE, et al. *Circ* 2023;148:1606-1635.

41

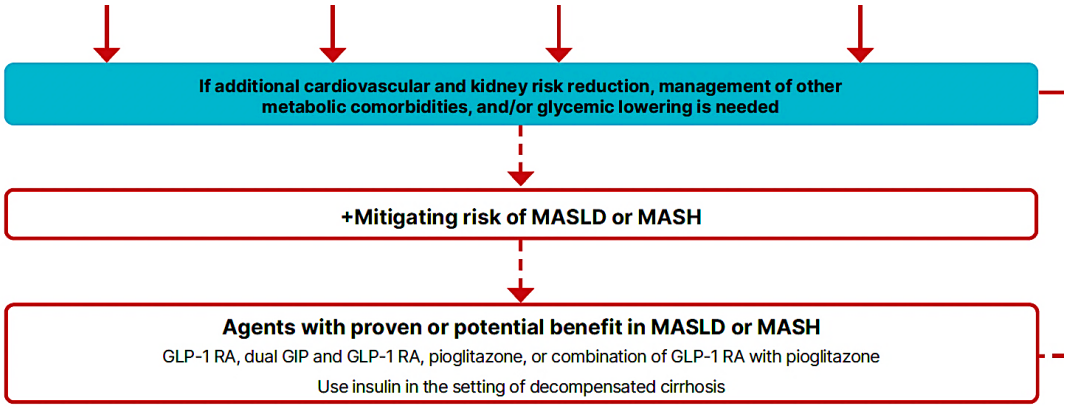
Choosing Glucose-Lowering Meds for T2D in 2026 – Alignment on MASLD by ADA and AACE



(1) ADA PPC. *Diabetes Care* 2026;49(Suppl. 1). (2) Samson SL, et al. *Endocr Pract* 2026;32:473-518.
Graphic prepared with help of Notebook LM AI using ADA and AACE guidelines as reference documents.

42

The ADA and AACE Agree That If Additional CV and Kidney Risk Reduction and/or Glucose-Lowering Is Needed, and to Mitigate Risk of MASLD or MASH, to Use GLP1-Based Drugs, Pioglitazone or Both



Samson SL, et al. AACE Consensus Statement: Algorithm for Management of Adults With Type 2 Diabetes — 2026 Update. *Endocr Pract* 2026;32:473-518.
ADA PPC. 9. Pharmacology Approaches to Glycemic Treatment: Standards of Care in Diabetes – 2026. *Diabetes Care* 2026;49(Suppl. 1).

43

GLP1RA and Eye Health

- Conflicting data on impact of GLP-1 RA on various facets of eye health, including development of nonarteritic anterior ischemic optic neuropathy, glaucoma, neovascular age-related macular degeneration (AMD), and diabetic retinopathy progression.
- GLP-1 RAs including liraglutide, semaglutide, and dulaglutide have been shown to be associated with a risk of mildly worsening diabetic retinopathy in randomized trials. Further data are needed.
- Retinopathy status should be assessed when glucose-lowering therapies are intensified, such as those using GLP-1 RAs, since rapid reductions in A1C have been shown to be associated with a risk of initial worsening of retinopathy.
- Some matched cohort studies link GLP-1 RAs with various ocular complications such as nonarteritic anterior ischemic optic neuropathy and AMD in people with diabetes, but data are limited and further studies are needed.
- GLP-1 RAs may have ocular benefits. Several studies have shown an association with GLP-1 RAs and lower intraocular pressure as well as a reduced risk of glaucoma

ADA PPC. 12. Retinopathy, Neuropathy and Foot Care: Standards of Care in Diabetes – 2026. *Diabetes Care* 2026;49(Suppl. 1):S261-S276.

44

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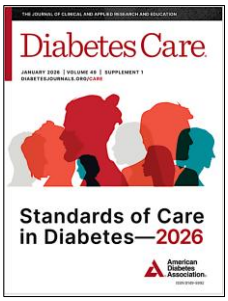
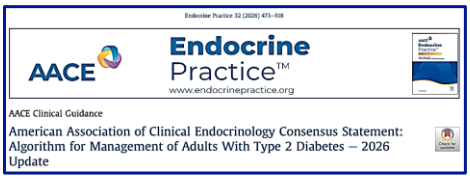




45

Diabetes and Bone Health

The T2D Bone Paradox

- People with T2D have 5-10% higher Bone Mineral Density (BMD) but significantly lower bone strength and higher fracture risk.
- The standard FRAX calculator systematically underestimates fracture risk in T2D. Apply a T-score adjustment of -0.5 SD.

Screening Protocol

Order DXA scans every 2–3 years for adults ≥65 years, or ≥50 years with specific diabetes risk factors.

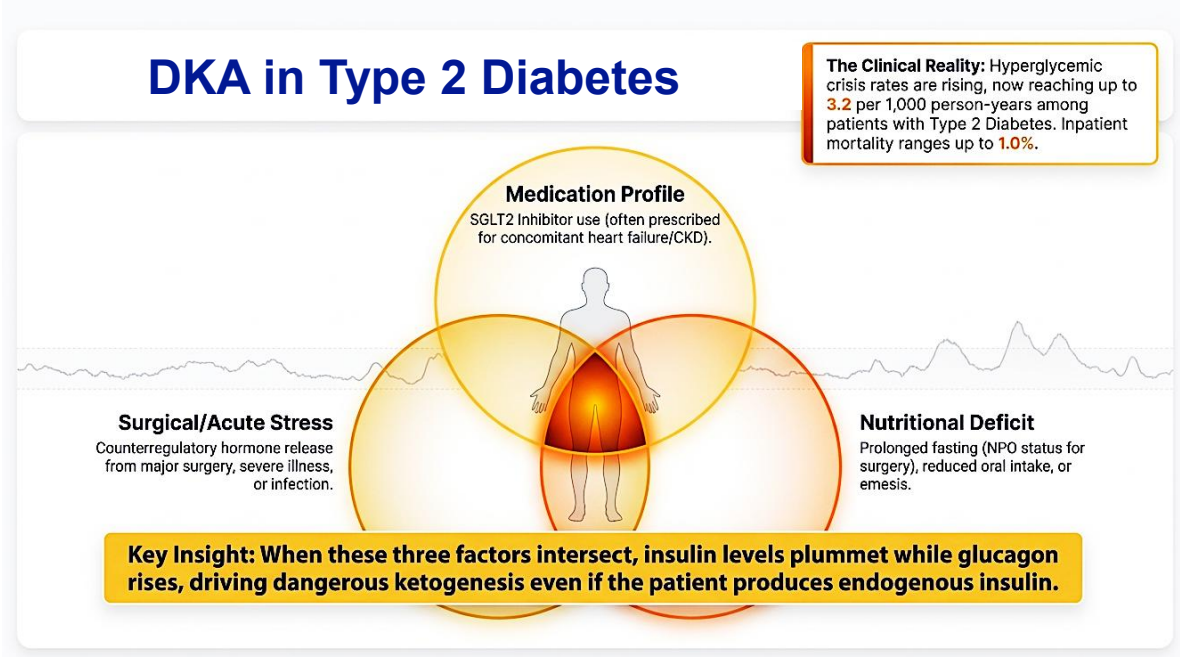
Treatment Cautions

Avoid Thiazolidinediones (TZDs) and Sulfonylureas in high-risk patients to prevent falls and bone loss.

Ensure Calcium (1,000–1,200 mg/day) and Vitamin D intake.

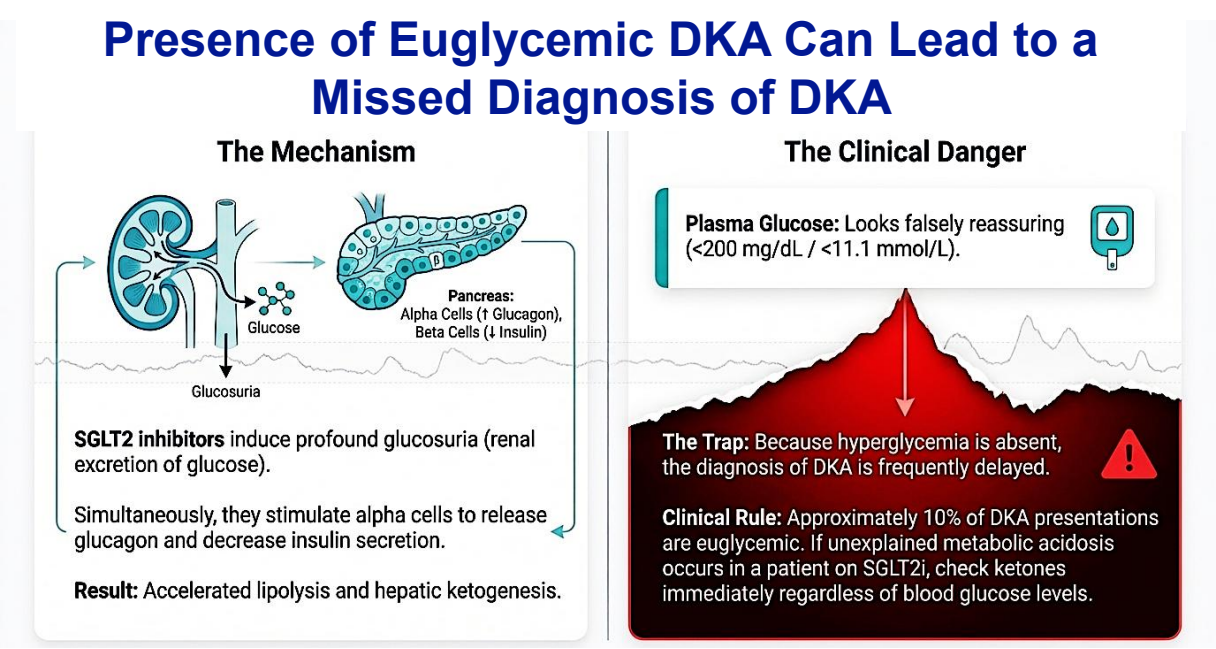
ADA PPC. 4. Comprehensive Medical Evaluation and Assessment of Comorbidities - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S61.

46



ADA PPC. 16. Diabetes Care in the Hospital - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S339-355.
Graphic prepared with help of Notebook LM AI using ADA standards as reference documents.

47



ADA PPC. 16. Diabetes Care in the Hospital - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S339-355.
Graphic prepared with help of Notebook LM AI using ADA and AACE guidelines as reference documents.

48

Diagnosing a Hyperglycemic Crisis in 2026

(Must Meet All Criteria)

Dimension	DKA (Diabetic Ketoacidosis)	HHS (Hyperglycemic Hyperosmolar State)
Dimension 1: Glycemic Level	Glucose ≥200 mg/dL (11.1 mmol/L) or history of diabete	Plasma glucose ≥600 mg/dL (33.3 mmol/L).
Dimension 2: Ketosis	β-Hydroxybutyrate ≥3.0 mmol/L or urine ketone strip 2+ or greater.	Absence of significant ketonemia (β-Hydroxybutyrate <3.0 mmol/L or urine ketone <2+).
Dimension 3: Acidosis	Venous pH <7.3 and/or bicarbonate <18 mmol/L.	Absence of acidosis (pH ≥7.3 and bicarbonate ≥15 mmol/L).
Dimension 4: Osmolarity	Variable.	Calculated effective serum osmolality >300 mOsm/kg.

Approximately one-third of hyperglycemic emergencies have a hybrid DKA-HHS presentation.

Umpierrez GE, et al. Hyperglycemic Crises in Adults With Diabetes: A Consensus Report. *Diabetes Care* 2024;47(8):1257-1275.
ADA PPC. 16. Diabetes Care in the Hospital - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S339-355.
Graphic prepared with help of Notebook LM AI using citations as reference documents.

49

Improving Post-Operative Outcomes

CGM Glucose Management Indicator (GMI) Goal

Day -4 to -3 (Hold SGLT2i)

Halt SGLT2 inhibitors (4 days for ertugliflozin, 3 days for others) to mitigate perioperative ketoacidosis risk.

Day -1 (Insulin Adjust)

Reduce basal insulin dose evening prior (e.g., reduce by 25%, or NPH by 50%) to prevent perioperative hypoglycemia.

Day 0 (Surgery/Procedure)

Target Goal: Maintain 100–180 mg/dL.

Monitoring: Check blood glucose every 2–4 hours while NPO. CGM should not be used alone during surgery.

Medications: Hold metformin and oral glucose-lowering agents. Re-evaluate GLP-1 RAs based on gastric emptying risk.

16.14 To improve postoperative outcomes after elective surgery, a preoperative A1C goal <8% (<64 mmol/mol) is recommended within 3 months, with individualized risk-to-benefit ratio assessment. **C** The 14-day glucose management indicator goal <8% and/or time in range >50% can also be used. **E**

ADA PPC. 16. Diabetes Care in the Hospital - Standards of Care in Diabetes - 2026. *Diabetes Care* 2026;49(Suppl. 1):S339-355.
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50

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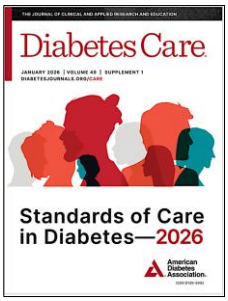
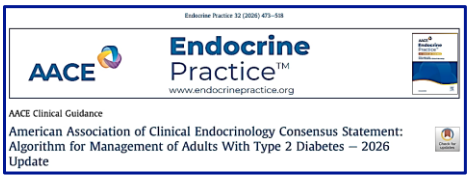
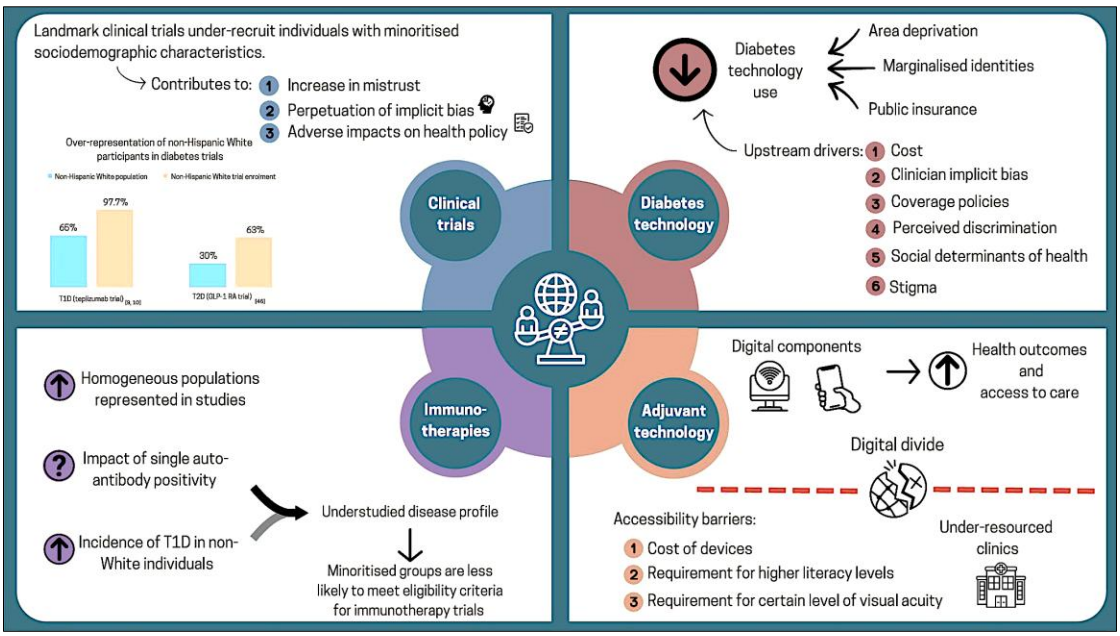




51



Addala A, et al. Disparities in access to and use of diabetes technologies and therapeutics: a narrative review. *Diabetologia* (2025) 68:2430–2448

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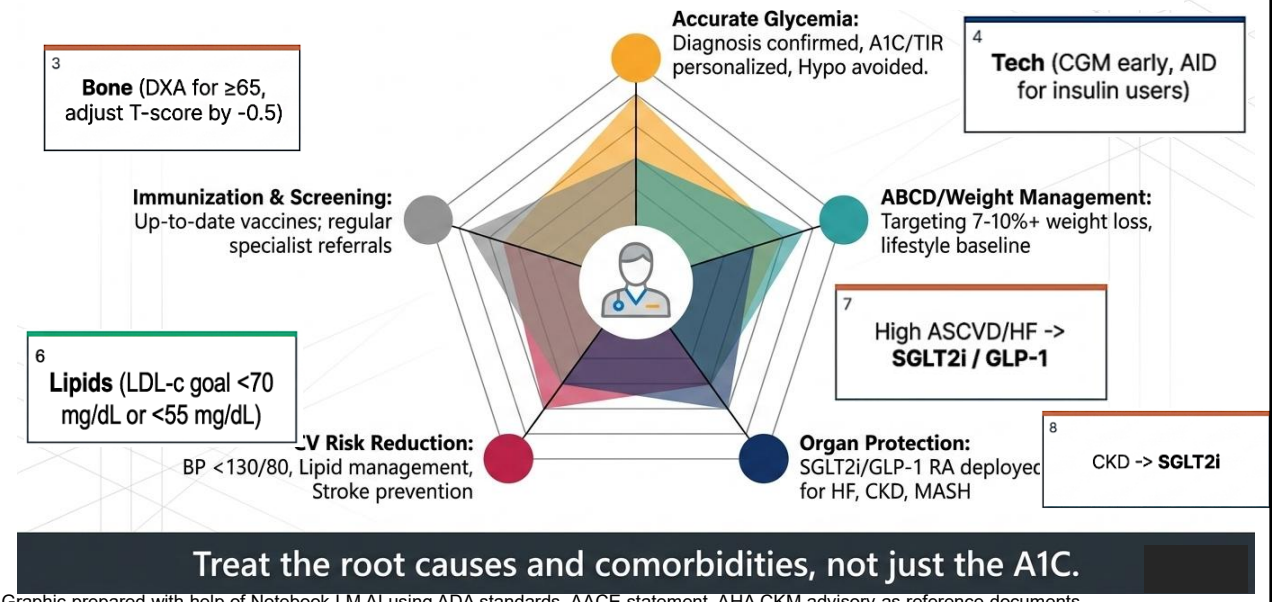
52

Type 2 Diabetes in 2026: The Whole Patient



Graphic prepared with help of Notebook LM AI using ADA standards, AACE statement, AHA CKM advisory as reference documents.

53

Training for Excellence in Diabetes Care
CU DIABETES FELLOWSHIP

We have a one-year Diabetes Fellowship Program
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American College of Diabetology

Excellence in Diabetes Care

The American College of Diabetology (ACD) is a physician-led nonprofit organization passionate about the management of diabetes mellitus with the goal of maintaining high standards in diabetes clinical care to improve the lives of those affected by diabetes.

www.acdiabetology.org

55

ARS Question #1

Continuous Glucose Monitoring (CGM) Is a New Standard of Care for Patients with Type 2 Diabetes as well as Those with Type 1 Diabetes.

What Does a 10% Increase in "Time-in-Range" (Glucose 70-180 mg/dL) Equate to in Terms of an A1c Decrease?

A. 0.1%
B. 0.3%
C. 0.5%
D. 0.8%
E. 1.0%

CONTINUING EDUCATION COMPANY

56

Take-Home Points for T2D in 2026

- Maintain a high index of suspicion for type 1 or other diabetes – type 2 diabetes and pre-type 2-diabetes is a diagnosis of exclusion.
- Low threshold for early initiation of CGM – it works, and it's standard of care. Time-in-range (TIR) goal ≥70% in most.
- Blood pressure goals are aggressive, and ACEi/ARB remain 1st line if albuminuria or established ASCVD
- LDL-c lowering: 50% reduction and absolute level of <70 mg/dL if multiple RF, <55 mg/dL if established ASCVD. Add ezetimibe to a statin if needed.
- Glucose-lowering: Multiple CVOTs demonstrating benefits of GLP1RA and SGLT2i, and MASLD is a new focus
- Diagnosis of DKA in diabetes: any glucose. Non-diabetes: ≥ 200 mg/dL
- Pre-operative glycemic goals: A1c <8% and/or CGM TIR >50%

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57