



Management of Type 2 Diabetes Mellitus

The following guideline applies to patients aged 18 years of age or older with type 2 diabetes mellitus. It recommends specific interventions for periodic medical assessment, laboratory tests and education to guide effective patient self-management.

Key Components

Assessment (at least every 6 months, more frequently as needed to support management of glycemia, weight, blood pressure, and secondary prevention interventions)

Glycemia: assess with A1c and/or glucose metrics from continuous glucose monitoring (CGM), when available [E]. Individualize the A1c goal based on age, comorbidities, hypoglycemia risk, life expectancy, pregnancy status, and patient goals. See box below for A1c targets.

Weight management: assess weight at least annually [E] and treat overweight or obesity as a primary goal of diabetes treatment [A]. Aim for 3-7% weight loss to improve glycemia and cardiovascular risk, and >10% when feasible to support remission, MASLD/MASH improvement, and long-term cardiometabolic benefit [B]. Minimize medications associated with weight gain [E].

Blood pressure: For confirmed hypertension and T2D, BP goal <130/80 if it can be safely achieved [A].

Social determinants and structural barriers: assess annually, especially food insecurity, housing stability, financial barriers, transportation access, health insurance status and community safety [A].

Additional assessment and interventions:

CVD/risk management: Calculate ASCVD risk and monitor lipid profile [E]; use moderate intensity statin for most patients 40-75 years of age without CVD [A]; high dose statin for all patients with higher CVD risk and established CVD [A]; use ASA 75-162 mg/day for established CVD unless contraindicated. [A]

Tobacco/nicotine cessation [A] including second-hand smoke avoidance. Recommend counseling and pharmacologic therapy (nicotine replacement and/or varenicline, bupropion, others). [A]

Retinopathy: initial fundoscopic exam by an ophthalmologist or optometrist. If retinopathy, repeat eye exam at least annually. If no retinopathy, every 1-2 years. Retinal photography may improve screening access. [B] Control glycemia, blood pressure and lipids to reduce risk and slow progression. [A]

Chronic kidney disease (CKD): assess spot urinary albumin-to-creatinine ratio (UACR) and estimated glomerular filtration rate (eGFR) at least annually [B]. Optimize glycemic and blood pressure control.

For CKD, use ACE inhibitor or ARB when albuminuria and hypertension are present, SGLT-2 inhibitor when eGFR allows, GLP-1 receptor agonist with cardiovascular benefit when additional glycemic/weight/CV benefit is needed, and non-steroidal mineralocorticoid receptor antagonist for persistent albuminuria when appropriate to reduce CKD progression and cardiovascular events [A/B].

Limit NSAIDs and other nephrotoxic medications. Refer to nephrology for eGFR <30, rapidly worsening eGFR, worsening albuminuria, resistant hypertension, or uncertain kidney disease etiology [A].

Foot care: comprehensive foot exam including 10-g monofilament test annually [B], then inspect feet at risk at every visit. [A] Provide foot care education including physical activity, appropriate footwear, nail and skin care. [B] Refer to podiatrist or foot care specialist if foot ulcers or high risk feet [B].

Refer for individualized medical nutrition therapy (MNT) and diabetes self-management education and support (DSMES) [A] from a collaborative team or diabetic educator.

Encourage moderate-to-vigorous exercise 150 minutes per week [B] and 2-3 sessions of resistance training per week [B].

Provide preconception counseling and family planning for pregnancy capable people and aim for preconception A1c <6.5%. [A]

Metabolic dysfunction-associated steatotic liver disease (MASLD): screen adults with T2D and obesity or cardiometabolic risk factors using Fibrosis-4 (FIB-4) index based on age, AST, ALT, and platelet count. If FIB-4 is indeterminate (1.3-2.67), further risk stratify with elastography or enhanced liver fibrosis (ELF) testing [B]. Refer to hepatology/gastroenterology for high-risk results (e.g., FIB-4 >2.67, elevated liver stiffness, or suspected advanced fibrosis) [B]. Treatment includes structured weight management; consider GLP-1 receptor agonist or dual GIP/GLP-1 receptor agonist for overweight/obesity with MASLD/MASH when clinically appropriate [B].

Immunizations: ensure appropriate immunization status [A], especially pneumococcal, influenza, COVID-19 and Hepatitis B.

Glycemic Control: Pharmacologic treatment should be individualized and selected to achieve glycemic goals while also addressing weight, hypoglycemia risk, cost/access, adverse effects, patient preferences, and comorbidities [E]. For adults with T2D and established/high-risk ASCVD, heart failure, or CKD, include SGLT-2 inhibitor and/or GLP-1 receptor agonist with proven benefit, independent of baseline A1c or metformin use when clinically appropriate [A]. Avoid concurrent GLP-1 receptor agonist and DPP-4 inhibitor therapy because added glucose-lowering benefit is not established [E]. Educate on self-monitoring of blood glucose and interpretation of CGM/BGM data to guide medication and lifestyle decisions [A]. Recommend CGM at diabetes onset and anytime thereafter for adults using insulin, those using therapies that can cause hypoglycemia, or any person for whom CGM data would aid management, reduce hypoglycemia, or support individualized treatment decisions [A/B].

A1c Targets:

<6.5% for women planning pregnancy [A]

<7% for many non-pregnant adults without hypoglycemia [A]

<8% for adults with limited life expectancy, substantial comorbidity/frailty, severe hypoglycemia risk, or for whom treatment harms are greater than benefits [B]

Avoid reliance on A1c and consider blood glucose monitoring (BGM) and/or CGM to achieve glycemic goals for individuals with recurrent hypoglycemia, severe cognitive impairment, advanced kidney disease, or limited life expectancy [E]

Weight Management:

Individualize obesity treatment and refer to medical nutrition therapy, use pharmacologic agents, or refer to metabolic surgery [A] based on patient motivation, preferences, and comorbidities.

Nutritional counseling should focus on caloric restriction and increasing daily consumption of non-starchy vegetables, moderate consumption of protein and heart healthy fats, and decreasing or eliminating simple sugars including sugar-sweetened beverages.

Offer or refer patients for medical evaluation of secondary causes of obesity including obesogenic medications, sleep apnea, hypothyroidism, etc.

Eliminate or replace obesogenic medications with weight negative or weight neutral medications when possible.

Hypertension control:

Evidence-based non-pharmacologic interventions for blood pressure management include a DASH-style eating pattern, weight loss when indicated, increased physical activity, salt restriction and alcohol reduction [A]. First-line medications include ACE-I/ARB, thiazide-like diuretic, or dihydropyridine CCB [A], refer to algorithm for hypertension treatment in T2D (S285 Figure 10.2).

ADA evidence grading system: A = randomized controlled trials; B = cohort or case control studies; C = poorly or uncontrolled studies or conflicting evidence; E = expert consensus or clinical experience

This guideline lists core management steps. Individual patient considerations, payer coverage, regulatory requirements, and advances in medical science may supersede or modify these recommendations.

Source references for July 2026 draft update: 1) American Diabetes Association Professional Practice Committee for Diabetes. Standards of Care in Diabetes—2026. Diabetes Care. 2026;49(Suppl 1):S1-S355. 2) American

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