



# Outpatient Type 2 Diabetes

ADA Standards of Care 2026 · targets, drug selection driven by comorbidity, and the annual screening set

Organ protection  
is not glycemia

## TARGETS *individualized, and the number is not the same for everyone*

### GLYCEMIA

**A1c < 7%** for most non-pregnant adults. **< 8%** is the safer target with limited life expectancy, advanced complications, extensive comorbidity or hypoglycemia unawareness. **A tighter number in a frail patient causes harm**, it does not earn credit.

### BLOOD PRESSURE

**< 130/80** on treatment. **SBP < 120 is encouraged when cardiovascular or kidney risk is high**, if it can be reached safely. **< 140/90** for older adults in poor health or with limited life expectancy.

### LIPIDS

Statin intensity by risk, not by LDL alone. **Do not add a fibrate, niacin or fish oil to a statin for cardiovascular risk reduction**: they add no further benefit. Fibrate remains appropriate for **triglycerides above 500** to prevent pancreatitis.

## DIAGNOSIS, AND WHEN THE A1c LIES *confirm with a repeat test unless the patient is unequivocally hyperglycemic*

### DIAGNOSTIC THRESHOLDS

**A1c ≥ 6.5%** · **fasting glucose ≥ 126** (8 h fast) · **2-h glucose ≥ 200** on 75 g OGTT · **random ≥ 200 with classic symptoms** or hyperglycemic crisis.

### PREDIABETES

**A1c 5.7 to 6.4%** · fasting **100 to 125** · 2-h **140 to 199**. Not a benign label: intensive lifestyle change, and **metformin is reasonable** particularly under age 60, with BMI ≥ 35, or after gestational diabetes.

### WHEN NOT TO TRUST THE A1c

It assumes a normal red cell lifespan. **Hemoglobinopathies, recent transfusion or blood loss, hemolysis, iron deficiency, erythropoietin, advanced CKD, dialysis and pregnancy all distort it**. Use fasting glucose, OGTT or CGM instead.

## DRUG SELECTION *the single most important idea on this page*

| Situation                                                       | What to use                                                                                                      | Why                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Everyone at diagnosis                                           | <b>Lifestyle plus metformin</b> . Metformin remains first-line for glycemic control                              | Effective, cheap, weight-neutral, no hypoglycemia alone. <b>ADA 2026 did not remove it</b> , despite what you may hear                                                                                                                                                                                                                             |
| ASCVD, or high cardiovascular risk                              | <b>GLP-1 RA</b> with proven benefit, <i>or</i> <b>SGLT2i</b> with proven benefit                                 | <b>These are indication-driven, not A1c-driven</b> . Start them for the organ indication <b>independent of the A1c and independent of whether the patient is on metformin</b> . ADA 2026 pushes them <b>earlier, considered from the point of diagnosis</b> in high-risk patients, because they are disease-modifying rather than glucose-lowering |
| Heart failure, any ejection fraction                            | <b>SGLT2i</b>                                                                                                    |                                                                                                                                                                                                                                                                                                                                                    |
| CKD (reduced eGFR or albuminuria)                               | <b>SGLT2i</b> preferred; <b>GLP-1 RA</b> if SGLT2i not tolerated. Add <b>finerenone</b> for residual albuminuria |                                                                                                                                                                                                                                                                                                                                                    |
| Obesity is the dominant problem                                 | <b>GLP-1 RA or dual GIP/GLP-1</b>                                                                                | Greatest weight effect, and weight loss drives blood pressure, lipids and hepatic steatosis at the same time                                                                                                                                                                                                                                       |
| Cost is the barrier                                             | Metformin, <b>sulfonylurea</b> , pioglitazone, human insulin                                                     | A cheap regimen taken beats an ideal regimen unfilled. Counsel on <b>hypoglycemia</b> with sulfonylureas and on weight gain and fluid retention with pioglitazone                                                                                                                                                                                  |
| <b>A1c far above goal</b> , or catabolic (weight loss, ketones) | <b>Insulin</b> , plus evaluate for type 1 or pancreatic diabetes                                                 | Do not titrate oral agents slowly in a patient who is losing weight and spilling ketones                                                                                                                                                                                                                                                           |

**Reconciling two 2026 guidelines that sound contradictory**. ADA keeps metformin first-line for glycemia. The 2026 CKM guideline, in a staged CKM population with PREVENT 10-year risk at or above 7.5%, makes the cardioprotective agent the Class 1 step and positions metformin as the Class 2a add-on for glycemic control. **Both are saying the same thing from different starting points**: the organ-protective drug is chosen for the organ, and metformin is chosen for the glucose.

## THE ANNUAL SET *what gets missed when the visit is only about the A1c*

| Check                          | How often                                                                  | What it is for                                                                                                                                                                                                                                                             |
|--------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| eGFR and UACR                  | <b>At least annually</b> , both                                            | <b>UACR is the one most often skipped</b> . Albuminuria appears before eGFR falls and independently predicts kidney and cardiovascular events. ACEi or ARB is <b>strongly recommended at UACR ≥ 300</b> , and suggested for hypertension with CAD or <b>UACR 30 to 299</b> |
| Dilated eye exam               | Annually. <b>Every 1 to 2 years</b> if no retinopathy and glycemia at goal | Retinopathy is asymptomatic until it is not. In T2DM, start screening <b>at diagnosis</b> , because the disease predates the diagnosis                                                                                                                                     |
| Comprehensive foot exam        | <b>At least annually</b> , more often if high risk                         | Identifies the neuropathy, deformity and vascular disease that precede ulceration and amputation. Inspect footwear at the same visit                                                                                                                                       |
| Lipids, blood pressure, weight | Every visit or annually                                                    | The cardiovascular risk is what most of these patients die of, not the hyperglycemia itself                                                                                                                                                                                |
| Vaccines, mental health, MASLD | Annually                                                                   | Influenza, pneumococcal, hepatitis B, COVID-19 and RSV per schedule. Screen for <b>depression and diabetes distress</b> , and calculate <b>FIB-4</b> for liver fibrosis                                                                                                    |

**Starting insulin**: basal **10 units daily**, or **0.1 to 0.2 units/kg/day**, titrated against the **fasting** glucose every few days. Add prandial insulin only once basal is optimized and the fasting number is at goal, otherwise you are treating the wrong meal. **On CGM, aim for time in range above 70% with under 4% of readings below 70 mg/dL**; a good time in range with frequent lows is not good control.

## PITFALLS & SAFETY

- SGLT2i: euglycemic DKA is the one to know**. Ketoacidosis with a near-normal glucose, so it is missed unless ketones are checked. **Hold during acute illness, prolonged fasting and before surgery**. Also counsel on genital mycotic infections and volume depletion.
- Expect an early eGFR dip after starting an SGLT2i and do not stop for it**. It is hemodynamic and precedes the long-term kidney benefit. Stopping the drug at the dip is the commonest way this benefit is lost.
- Metformin is a lactic acidosis question, not a kidney question**. Continue to **eGFR 30**, do not start below 45, and hold around iodinated contrast and acute illness. Check **B12** on long-term use.
- Do not stack incretins**. A GLP-1 RA plus a DPP-4 inhibitor adds no benefit; stop the DPP-4 inhibitor when starting a GLP-1. Reduce sulfonylurea or insulin when adding a GLP-1 or SGLT2i to avoid hypoglycemia.

