



The 2024 ADA Standards of Care: What's new?

The American Diabetes Association (ADA)'s Standards of Care in Diabetes are “living guidelines” and are updated throughout the year as significant new evidence becomes available, with a full update published each January. This *At a glance factsheet* highlights key changes that were published in January 2024. Although some sections of the Standards reflect US practice, diabetes care is becoming more globally unified, so most recommendations are relevant to healthcare professionals in the UK. The changes highlighted here focus on those relevant to primary and community care teams.

Author: Pam Brown, GP, Swansea.

Citation: Brown P (2024) At a glance factsheet: The 2024 ADA Standards of Care: What's new? *Diabetes & Primary Care* 26: 17–18

General changes

- Language changes: Person-first, culturally sensitive and inclusive language; terminology designed to empower people.

Section 1. Improving care and promoting health in populations

- Additional cost data, particularly regarding insulins and glucose monitoring technology. For UK prices, consult BNF or Summary of Product Characteristics

Section 2. Diagnosis and classification

- More structured approach to diagnostic testing including confirmation of initial diagnosis, with a focus on HbA_{1c} use.
- Standardised islet autoantibody testing to help differentiate classification.
- Screening recommendations in those treated with second-generation antipsychotic drugs, those with acute or chronic pancreatitis, and those with cystic fibrosis.

Section 3. Diabetes prevention

- Monitor people at risk of developing type 1 diabetes. Teplizumab recommended to delay onset of stage 3 (symptomatic) type 1 diabetes in people aged 8 years or older with preclinical (stage 2) type 1 diabetes.

Section 4. Medical evaluation and comorbidities assessment

- Immunisations: Added respiratory syncytial virus vaccine in adults aged ≥60 years.
- Bone health: Extensively revised/updated – regular review, identification and management. New Table 4.5 summarises fracture risk factors.
- Liver disease: 2023 “Living Standard” changes incorporated, including screening and management recommendations. Proposed nomenclature changes (metabolic dysfunction-associated steatotic liver disease; MASLD) discussed but not implemented.

Section 5. Positive health behaviours

- Focus on guiding healthcare professional behaviour rather than patient behaviour.
- Five critical times to evaluate need for structured diabetes

education: diagnosis; not meeting treatment targets; annually; when complicating factors (medical/physical/psychosocial) develop; transitions in life and care.

- Medical nutrition therapy: Updated general diet guidance for diabetes, healthy fats, religious fasting, chrononutrition, non-nutritive sweeteners (based on 2023 WHO guidance).
- Physical activity: Updated to define sedentary behaviour, benefits of high-intensity training.
- Smoking cessation: Ask and refer. Cannabis discussion added.
- Implement psychosocial screening protocols consistently (for diabetes distress, stress, quality of life, financial/social/family/emotional resources, psychiatric history, depression, fear of hypoglycaemia).
- Encourage sleep-promoting routines.

Section 6. Glycaemic goals and hypoglycaemia

- Hypoglycaemia guidance consolidated here from other sections.
- Discussion of strengths and limitations of HbA_{1c} and other glycated proteins.
- CGM metrics added to glycaemic goals section.
- Deintensification of medication added.
- Increased focus on assessing, preventing and managing hypoglycaemia risk, awareness and hypo education.

Section 7. Technology

- Clinicians to upskill as required to assist with devices and technology.
- Recommendations reflecting benefits of CGM and automated insulin devices for additional groups.

Section 8. Obesity and weight management

- Importance of weight management in diabetes; benefits gained by different weight loss achievements.
- Use BMI and measures of body fat distribution (e.g. waist circumference, waist:hip ratio, waist:height ratio).
- Individualise management; consider all approaches (behavioural, pharmacological, surgical).
- Weight maintenance programmes recommended for those who achieve weight loss.
- Effective GLP-1 or GIP/GLP-1 receptor agonists (i.e. semaglutide, tirzepatide) recommended as pharmacotherapies of choice.

- Emphasis on re-evaluating treatment, goals and preventing therapeutic inertia.
- Consider long-term benefits of surgery, monitor post-surgery weight loss and explore barriers and additional interventions if needed.

Section 9. Pharmacological approaches to glycaemic treatment

- Analogue (or inhaled) insulins preferred for most with type 1 diabetes to minimise hypoglycaemia.
- Consider glucagon (preferably ready-to-use) for those taking insulin or at high risk of hypos.
- Consider early combination therapy in type 2 diabetes to shorten time to achieving treatment goals.
- Intensify treatment to achieve glycaemic and weight loss goals in people with type 2 diabetes and no CVD/CKD comorbidities. Individualise choices and prioritise drugs which reduce CVD, heart failure and CKD.
- GIP/GLP-1 receptor agonists added as options alongside GLP-1 receptor agonists for treatment escalation, in preference to or in combination with insulin.
- Consider insulin at any stage in individuals who need it, but adjust doses of other glucose-lowering medications if hypo risk.

Section 10. Cardiovascular disease

- Bempedoic acid recommended as an option for primary prevention in statin-intolerant people. Bempedoic acid, PCSK9 inhibitors and inclisiran recommended as alternative/additional lipid-lowering therapies if intolerant or not meeting targets. New subsection on Statin Intolerance.
- Screen for asymptomatic heart failure in people with diabetes using BNP or NT-proBNP.
- Screen for asymptomatic peripheral arterial disease using ankle-brachial index if age ≥ 50 years, any microvascular disease, foot complications, diabetes end-organ damage and in those with diabetes of ≥ 10 years' duration.
- Use SGLT2 or SGLT1/2 inhibitors if diabetes and established heart failure (all types).
- If using SGLT2 inhibitors, educate on risks and signs of ketoacidosis in type 1 or ketosis-prone diabetes, and if eating ketogenic diet (other guidance recommends this for everyone taking SGLT2 inhibitors).

Section 11. Chronic kidney disease

- Updated to align with 2023 ADA and KDIGO consensus on diabetes management in CKD 2023, including CKD progression, monitoring and referral recommendations.

- ACE inhibitors or ARBs recommended in people with uACR 30–299 mg/g (approximately 3–30 mg/mmol) and strongly recommended in those with uACR ≥ 300 mg/g (30 mg/mmol) and/or eGFR < 60 mL/min/1.73 m², to slow renal progression and reduce cardiovascular events.

Section 12. Retinopathy, neuropathy and foot care

- Updated to include use of FDA-approved AI algorithms to analyse retinal photography to improve access to screening; importance of evaluation and rehabilitation of visual loss.
- Limited evidence for lidocaine 5% plasters/patches for neuropathy pain and gastric stimulation for gastroparesis.
- Specialist multidisciplinary management for those with foot ulcers and/or high-risk feet.

Section 13. Older adults

- Individualise glycaemic goals due to heterogeneity of older people with diabetes. Stronger recommendations made to deintensify/switch to medications with lower hypoglycaemia risk.
- Emphasis that older people with comorbidities should be offered drugs that improve cardiorenal outcomes, irrespective of glycaemia.

Section 14. Children and adolescents

- Diagnose and manage psychosocial needs.
- Comprehensive lifestyle intervention aiming for at least 7–10% weight loss.
- Empagliflozin added to the list of agents recommended for treatment escalation in children and young people aged ≥ 10 years.
- Discourage starting smoking and encourage cessation.

Section 15. Pregnancy

- Glucose monitoring updated to include recommendation for CGM in women with type 1 diabetes and consideration in those with type 2 or gestational diabetes.
- Metformin and glyburide not to be used first-line.
- Aspirin for pre-eclampsia to be considered in gestational diabetes if single high risk factor or multiple moderate risk factors.
- Encourage breastfeeding for all with diabetes. ■