Table 1
Summary of Questions
Q = Question

Section 1	**Screening, diagnosis, glycemic targets, glycemic monitoring**
Q1	How is the diagnosis of DM made and what is the current screening protocol for prediabetes and diabetes?
Q2	What are the glycemic treatment goals for persons with DM?
Q3	When and how should glucose monitoring be used?
Section 2	**Comorbidities and complications**
Q4	How should hypertension be managed in persons with DM?
Q5	How should dyslipidemia be managed in persons with DM?
Q6	How should DKD or CKD in DM be managed?
Q7	How should retinopathy be managed in persons with DM?
Q8	How should neuropathy be diagnosed and managed in persons with DM?
Q9	How should antihyperglycemic agents be prioritized in persons with T2D at high risk for/or with established CVD?
Q10	How should obesity be managed in persons with DM?
Section 3	**Management**
Q11	How should prediabetes be managed?
Q12	How can glycemic targets be achieved in persons with T2D?
Q13	How should insulin therapy be used for management of persons with T1D?
Q14	How should hypoglycemia be managed?
Q15	How should DM be managed in the hospital?
Q16	How should DM in pregnancy be managed?
Section 4	**Education and other topics**
Q17	What education interventions have been shown to be most effective in management of persons with DM?
Q18	What are the key nonpharmacological components of a comprehensive diabetes care plan in children and adolescents?
Q19.1	Should persons with infertility be screened for DM?
Q19.2	How should persons with preexisting diabetes mellitus and infertility be evaluated?
Q19.3	Should men with DM and cardiometabolic disorders be assessed for hypogonadism?
Q20.1	How should persons at risk for secondary diabetes be assessed?
Q20.2	What are the best treatment strategies for management of secondary diabetes, such as posttransplant diabetes, cystic fibrosis–related diabetes, and other forms of secondary diabetes?
Q21	What is the role of sleep medicine in the care of persons with DM?
Q22	Should screening for depression be a routine component of clinical assessment in persons with DM?
Q23	Is the evaluation of SDOH in persons predisposed to or with DM useful in improving health outcomes?
Q24	Is telehealth/virtual care an effective care-delivery model for the management of persons with DM?
Q25	Which occupations have specific public safety–related diabetes management considerations?
Q26	Is there a role for nutritional supplements in the management of DM and what might be the associated risks?
Q27	How should potential increased cancer risk be managed in persons with obesity/T2D?
Q28	Which vaccinations should be given to adults with DM?

Abbreviations: CKD, chronic kidney disease; CVD, cardiovascular disease; DKD, diabetic kidney disease; DM, diabetes mellitus; SDOH, social determinants of health; T1D, type 1 diabetes, T2D, type 2 diabetes.

Table 2
Summary of Recommendations

Section 1. Screening, Diagnosis, Glycemic Targets, Glycemic Monitoring	
Q 1: How is the diagnosis of diabetes mellitus made and what is the current screening protocol for prediabetes and diabetes?	
R 1.1	The diagnosis of diabetes mellitus (DM) is based on the following criteria (Table 4): • Fasting plasma glucose (FPG) concentration ≥126 mg/dL (after ≥8 h of an overnight fast), or • Plasma glucose (PG) concentration ≥200 mg/dL 2 h after ingesting a 75-g oral glucose load after an overnight fast of at least 8 h, or • Symptoms of hyperglycemia (eg, polyuria, polydipsia, polyphagia) and a random (nonfasting) PG concentration ≥200 mg/dL, or • Hemoglobin A1c (A1C) level ≥6.5% Diagnosis of DM requires 2 abnormal test results, either from the same sample or two abnormal results on samples drawn on different days. However, a glucose level ≥200 mg/dL in the presence of symptoms for DM confirms the diagnosis of DM. Grade A; BEL 2 and expert opinion of task force
R 1.2	Prediabetes is identified by the presence of impaired fasting glucose (IFG) (100 to 125 mg/dL), impaired glucose tolerance (IGT), which is a PG value of 140 to 199 mg/dL 2 h after ingesting 75 g of glucose, and/or A1C value between 5.7% and 6.4% (Table 4). A1C should be used only for screening for prediabetes. The diagnosis of prediabetes, which may manifest as either IFG or IGT, should be confirmed with glucose testing. Grade B; BEL 2
R 1.3	Type 1 diabetes (T1D) is characterized by marked insulin deficiency in the presence of hyperglycemia and positive autoantibody tests to glutamic acid decarboxylase (GAD65), pancreatic islet β cells (tyrosine phosphatase IA-2), and IA-2b zinc transporter (ZnT8), and/or insulin. The presence of immune markers and clinical presentation are needed to establish the correct diagnosis and to distinguish between T1D and type 2 diabetes (T2D) in children or adults, as well as to determine appropriate treatment. Grade A; BEL 2
R 1.4	T2D is characterized by progressive loss of β-cell insulin secretion and variable defects in insulin sensitivity. T2D is often asymptomatic and can remain undiagnosed for many years; therefore, all adults ≥35 y of age with risk factors should be screened for DM (Table 5). Grade A; BEL 1
R 1.5	Gestational diabetes mellitus (GDM) is defined as carbohydrate intolerance that begins or is first recognized during pregnancy and resolves postpartum. Pregnant women with risk factors for DM should be screened at the first prenatal visit for undiagnosed T2D using standard criteria (Table 4). Grade B; BEL 1
R 1.6	Screen all pregnant women for GDM at 24 to 28 weeks' gestation. Diagnose GDM with either the one-step or the two-step approach. • The one-step approach uses a 2-h 75-g oral glucose tolerance test (OGTT) after ≥8 h of fasting with diagnostic cutoffs of one or more FPG ≥92 mg/ dL, 1-h PG ≥180 mg/dL, or 2-h PG ≥153 mg/dL. • The two-step approach uses a nonfasting 1-h 50-g glucose challenge test with 1-h PG screening threshold of 130 or 140 mg/dL. For women with a positive screening test, the 3-h 100-g OGTT is used for diagnosis with 2 or more PG tests that meet the following thresholds: FPG ≥95 mg/dL, 1-h ≥180 mg/dL, 2-h ≥155 mg/dL, 3-h ≥140 mg/dL. Grade A; BEL 1