

ADA releases 2026 standards to guide obesity screening, diagnosis, evaluation, and staging

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Recently, the American Diabetes Association (ADA) Professional Practice Committee for Obesity released its Standards of Care in Overweight and Obesity-2026, offering important clinical guidance for preventing and delaying disease associated with excess adiposity.¹ Although the ADA has long incorporated weight management into its diabetes guidelines, most recently emphasizing that a 5-7% reduction in body weight can improve glycemia and other cardiometabolic risks and >10% weight loss may induce remission of type 2 diabetes,² this is the first time the organization has issued a dedicated, comprehensive guideline focused specifically on the screening, diagnosis,

evaluation, and staging of obesity (Figure 1). The addition of waist circumference-based criteria to BMI for diagnosing obesity, the emphasis on the Edmonton Obesity Staging System (EOSS) for risk stratification, and the longitudinal approach to obesity screening and management, all reflect the growing recognition that obesity is not merely a risk factor but a chronic disease that warrants greater clinical attention.

Emerging evidence indicates that excess adiposity affects multiple organ systems, including cardiometabolic, gastrointestinal, respiratory, musculoskeletal, neurocognitive, oncologic, renal, reproductive, dermatologic,

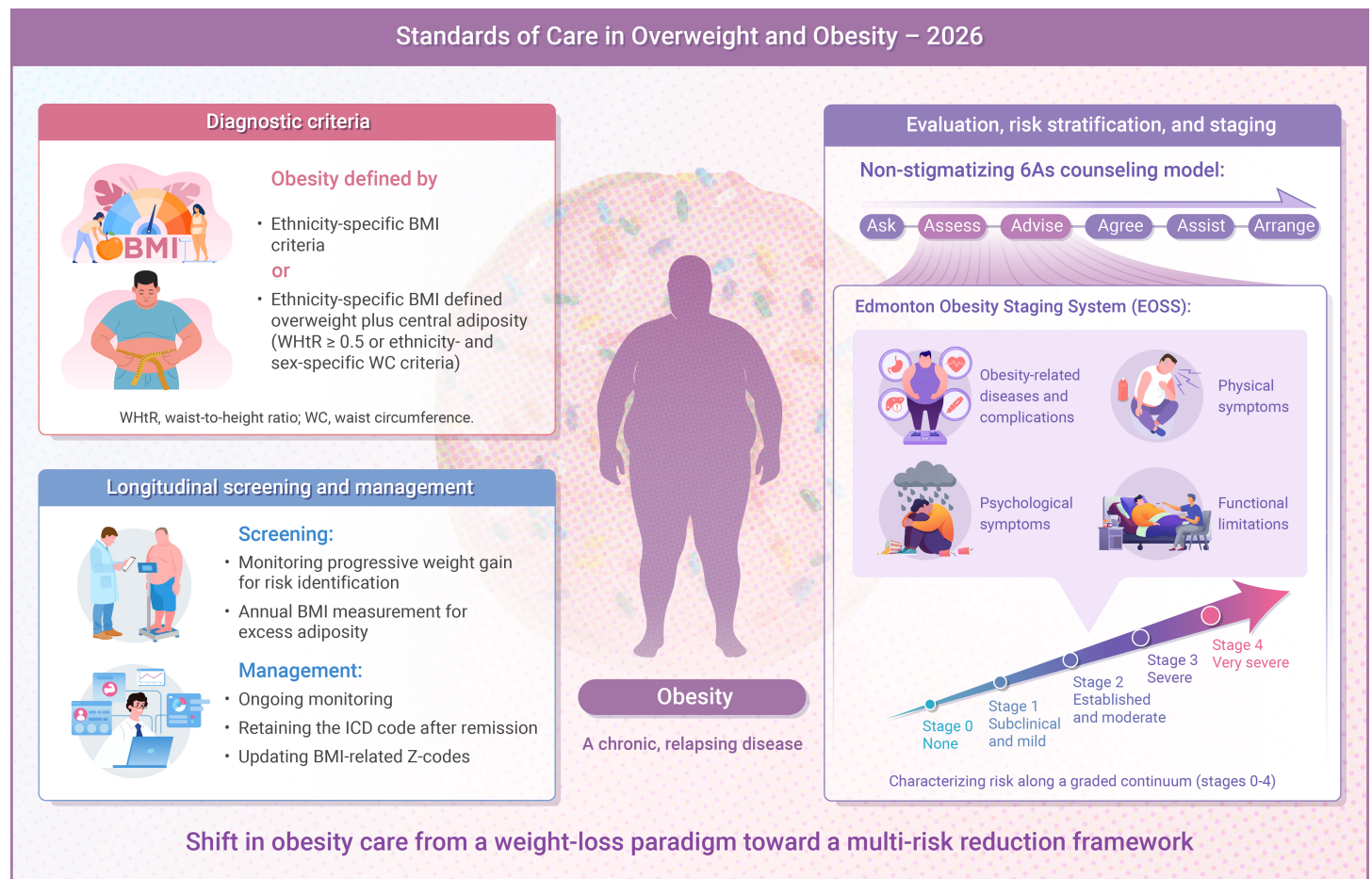


Figure 1. Standards of care in overweight and obesity-2026.

endocrine, and immune systems, resulting in broad and significant health consequences. Accordingly, obesity has long been recognized as a major risk factor that substantially increases morbidity and premature mortality. However, its status as a standalone disease entity remains contested, largely because the specific illnesses directly attributable to obesity and its precise clinical definition have not been clearly established. Despite its simplicity and long-standing use in diagnosing obesity, BMI has notable limitations as a measure of excess adiposity.³ It does not distinguish between fat and lean mass or capture adipose-tissue distribution, a key determinant of cardiometabolic risk. As a result, muscular individuals may be misclassified as overweight or obese, whereas those with normal BMI but excess visceral

adiposity may be overlooked. Moreover, BMI does not directly reflect obesity-related health outcomes, underscoring its inadequacy as a standalone indicator for obesity diagnosis and risk stratification. Against this backdrop, in 2025, the Lancet Diabetes & Endocrinology Commission proposed a definition for clinical obesity that incorporates both excess adiposity and obesity-related impairments in organ or tissue function or daily activities.⁴ This reframing moves beyond the traditional BMI-centered definition of obesity and instead conceptualizes obesity and its pathophysiologic consequences as an integrated entity. However, subsequent appraisal of this framework highlighted implementation challenges, such as its reliance on causal adjudication, ambiguous preclinical category, and burdensome diagnostic require-

ments.⁵ Therefore, the Endocrine Society recommends prioritizing early identification of central obesity, emphasizing continuous risk quantification instead of a two-state diagnostic structure, and allocating treatment resources according to expected clinical benefits.

The ADA Professional Practice Committee for Obesity's 2026 Standards introduce a pragmatic, practice-oriented risk reduction approach that integrates BMI with simple anthropometric measures to improve identification of individuals at metabolic risk.¹ For adults whose BMI falls within the overweight range, the 2026 Standards recommend incorporating waist-to-height ratio (WHtR) ≥ 0.5 or waist circumference thresholds to detect central adiposity, measures that are feasible in routine clinical care and do not require specialized imaging. This combined-measure strategy is applied across populations, with diagnostic thresholds calibrated to reflect differences in metabolic susceptibility. In non-Asian adults, obesity is diagnosed when excess adiposity is identified using BMI ≥ 30 kg/m² or BMI ≥ 25 kg/m² in the presence of central adiposity, while overweight is defined by BMI 25–29.9 kg/m² in the absence of central adiposity. For Asian adults, lower BMI thresholds (≥ 23 kg/m² for overweight and ≥ 27.5 kg/m² for obesity) are paired with the same requirement for WHtR or ethnicity-specific waist circumference thresholds (≥ 80 cm for women, ≥ 90 cm for men) to determine the presence of central adiposity. Collectively, this framework highlights the 2026 Standards' commitment to a clinically practical, anthropometry-based diagnostic model that accounts for population-specific metabolic vulnerability. As a complement, in individuals with predominantly higher muscle mass, additional methods such as bioelectrical impedance analysis or dual-energy X-ray absorptiometry should be used to more accurately assess body composition.

Beyond diagnostic criteria, the 2026 Standards also underscore the importance of structured risk stratification and staging, with particular emphasis on the EOSS.¹ EOSS incorporates assessment across four domains, including obesity-related diseases and complications, physical symptoms, psychological symptoms, and functional limitations, characterizing risk along a graded continuum (stages 0–4) rather than imposing a strict health-illness dichotomy. By linking each stage to corresponding treatment options and levels of intervention, EOSS provides practical guidance for clinical decision-making. Its focus on functional impairment is also consistent with emerging coverage decisions for pharmacologic and surgical treatments, which are shifting away from reliance on BMI thresholds alone.⁵ Incorporating EOSS allows clinicians to identify individuals with substantial metabolic risk even when their BMI is only moderately elevated. To embed staging with shared decision-making and minimize stigma, the 2026 Standards integrate the EOSS assessment with the 6As Counseling Model (Ask, Assess, Advise, Agree, Assist, Arrange). This framework promotes patient-centered, non-stigmatizing communication and ensures that staging results directly shape individualized care plans. Under this integrated structure, treatment goals shift from weight-centric targets to clinically meaningful endpoints such as improved glycemic control, reduced hepatic steatosis, enhanced physical functioning, and alleviation of psychological symptoms. As a result, management plans are positioned within a unified therapeutic continuum in which eligibility is guided by EOSS stage rather than BMI alone. This approach reflects a broader shift in obesity care from a weight-loss paradigm toward a multi-risk reduction framework.

Recognizing that obesity progresses along a dynamic and often relapsing trajectory, the 2026 Standards introduce a longitudinal approach for obesity screening and management.¹ They recommend routine monitoring for progressive weight gain as a strategy to identify adults at increased risk for developing obesity and its related complications, noting that annual weight increases exceeding 1.0–1.5 kg over more than three years may signal heightened vulnerability. In addition, the 2026 Standards call for annual BMI measurement to screen for excess adiposity, consistent with recommendations outlined in the latest ADA Standards of Care in Diabetes.² For individuals undergoing obesity treatment, the 2026 Standards advise regular follow-

up at intervals aligned with the selected treatment plan. Follow-up frequency should be individualized according to the EOSS stage, with higher stages warranting more intensive and more frequent monitoring. These encounters should include assessment of the treatment efficacy, safety, and tolerability; ongoing monitoring of anthropometric measurements and relevant health outcomes (such as those captured within the EOSS framework); and systematic exploration of barriers to adherence, accompanied by collaborative problem-solving when challenges arise. The 2026 Standards further recommend reassessing psychosocial and behavioral factors that may influence treatment outcomes, ensuring that management remains responsive to the individual's evolving needs. To operationalize obesity as a chronic disease, the 2026 Standards also provide guidance on diagnostic coding practices. Clinicians are advised to maintain the primary ICD-10 code for obesity (E66 range) even when remission is achieved, while updating BMI-related Z-codes to reflect current measurements. This practice supports continuous monitoring, allows early detection of weight regain, and helps ensure uninterrupted access to pharmacotherapy by reducing the risk of insurance-related treatment disruptions. In doing so, the 2026 Standards align obesity coding with conventions used for other chronic diseases, where remission does not eliminate the need for ongoing monitoring.

In summary, the ADA Professional Practice Committee for Obesity's 2026 Standards provide a comprehensive, evidence-based framework for diagnosing and managing obesity as a chronic, relapsing, and dynamically evolving disease. By emphasizing central adiposity measures, EOSS staging criteria, longitudinal monitoring, and strategies to reduce stigma, the 2026 Standards establish a structured framework aimed at standardizing clinical practice and enhancing treatment effectiveness. Given that obesity prevalence continues to rise globally and remains the strongest modifiable determinant of type 2 diabetes, implementation of these Standards represents a direct extension of the ADA's mission to prevent diabetes and reduce its long-term complications. While the impact of these recommendations on population-level outcomes will depend on factors such as clinician uptake, health-system capacity, reimbursement policies, and broader access to effective obesity care, the 2026 Standards nevertheless represent a notable progression. They offer a meaningful advance in aligning obesity management with current scientific evidence and integrating it more fully into the framework of chronic disease care.

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DECLARATION OF INTERESTS

The author declares no competing interests.