Why Don’t More Patients have CGM?

- Approximately 90% of diabetes care in the US occurs in the primary care setting.
- The American Diabetes Association (ADA) and the American Association of Clinical Endocrinology (AACE) recommend the use of CGM for many patients with diabetes.
- CGM is associated with many benefits for patients with diabetes, including improved health behaviors, reductions in A1c, less hypoglycemia, decreases in body weight, reduced caloric intake, increased physical activity, improved treatment satisfaction, and adherence to a personal eating plan.

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Unger J, et al. *Postgraduate Medicine*. 2020; ADA. *Diabetes Care*. 2026; Oser TK, et al. *Ann Fam Med*. 2022.

Why Don’t More Patients have CGM?

For clinicians, the benefits are also many: more informed treatment decisions, more engagement with the patient, greater insight into therapeutic impact – so much more information than the A1c provides.

EDITOR'S PICK

TOP STORY

The CGM Adoption Gap Is Worse Than You Think

A new study found that continuous glucose monitors can cut healthcare costs by about 20% while also improving outcomes for insulin-dependent diabetes patients, largely by reducing hospitalizations and emergency department visits. Despite these benefits and broad insurance coverage, roughly 80% of eligible patients still are not using the technology — highlighting a significant adoption gap.

Miller EM. *Clin Diabetes*. 2020; Adams K. *MedCity News*. 2025.

Benefits of CGM

- A1C Reduction – Still Matters, But It's Not the Whole Story
- A1C remains a familiar, validated endpoint tied to long-term complication risk.
- CGM consistently demonstrates modest but clinically meaningful A1C reductions across populations
  - DIAMOND Trial (T1D & T2D on MDI) CGM users greater A1C reduction vs SMBG at 24 weeks
  - GOLD Trial (T1D) CGM reduced A1C by ~0.4% compared with fingerstick monitoring
  - MOBILE Study (T2D on basal insulin) CGM resulted in greater A1C reduction compared with SMBG, even without prandial insulin
- Time in Range (TIR) – The Most Actionable Metric
- ADA now emphasizes TIR as a key glycemic outcome, complementary to A1C
- TIR reflects daily glucose stability, not just averages
- Strongly associated with risk of microvascular complications
  - GOLD Trial – Significant increases in TIR with CGM
  - DIAMOND Trial – CGM users spent more time 70–180 mg/dL and less TAR
  - Real-world registry studies show consistent TIR improvements across age groups and diabetes types.

Beck RW, et al. *JAMA*. 2017; Lind M, et al. *JAMA*. 2017; Martens T, et al. *JAMA*. 2021; Brown RE, et al. *Diabet Med*. 2022; Dowd R, et al. *JMIR Diabetes*. 2023; Gavin JR, et al. *Diabetes Technol Ther*. 2021.

ADA SOC Perspective on CGM

What's changed in 2026 and why are we so excited for these changes?

- CGM is now recommended from diagnosis and anytime thereafter for all people on insulin, on non-insulin therapies that can cause hypoglycemia, and any therapy where CGM helps management
- It's no longer optional for Type 1 or people with insulin-treated T2D; it's standard of care

ADA. *Diabetes Care*. 2026.

ADA SOC Perspective on CGM

Continuous Glucose Monitoring (CGM) Devices
2026 ADA Recommendations

7.15 Use of **CGM is recommended at diabetes onset and anytime thereafter** for children, adolescents, and adults with diabetes who are on insulin therapy, on noninsulin therapies that can cause hypoglycemia, and on any diabetes treatment where CGM helps in management. The specific CGM device and method for use should be made based on the individual's circumstances, preferences, and needs

7.16 In people with diabetes on insulin therapy, CGM devices should be used as close to daily as possible for maximal benefit. People with diabetes should have uninterrupted access to their supplies to minimize gaps in CGM.

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ADA. *Diabetes Care*. 2026.

Hypoglycemia Reduction

The Most Persuasive Safety Argument…

- Hypoglycemia is linked to falls, cognitive impairment, cardiovascular events, and mortality
- Prevention is a core responsibility emphasized in ADA 2026 Standards
  - IN CONTROL Trial (T1D with impaired awareness) CGM significantly reduced time spent <70 mg/dL compared with SMBG
  - WISDM Study (Older adults with T1D) CGM reduced hypoglycemia and improved patient-reported outcomes.
  - IMPACT Trial (Flash CGM)Significant reduction in hypoglycemia exposure without worsening A1C
  - MOBILE Study (T2D on basal insulin)Reduced hypoglycemia alongside improved overall glycemia

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van Beers CA, et al. *Lancet Diabetes Endocrinol*. 2016; Pratley RE, et al. *JAMA*. 2020; Oskarsson P, et al. *Diabetologia*. 2018; Martens T, et al. *JAMA*. 2021.

Why Patients (and Clinicians) Need CGM

Diabetes is continuous

The majority of diabetes care transpires between visits, outside of clinical encounters.

A1C alone may not be enough

Using A1C alone may not be very helpful to patients for understanding their diabetes.

BGM has notable limitations

It only measures blood glucose at a single point in time.

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A1C, glycated hemoglobin or HbA1C; BGM, blood glucose monitoring.

Corathers SD, et al. *Diabetes Spectr*. 2020; Garber A, et al. *Endocr Prac*. 2020; Adolfsson P, et al. *Eur Endocrinol*. 2018.

CGM EARLY Can Support Glycemic Outcomes

Reaching & sustaining **A1C targets in the first year of treatment**, showed long-term health improvements, even when control waned over time.

Managing glucose levels early in diagnoses **reduces chance of complications.**

People with T2D that achieve targets soon after diagnosis are more likely to **keep glucose in target range.**

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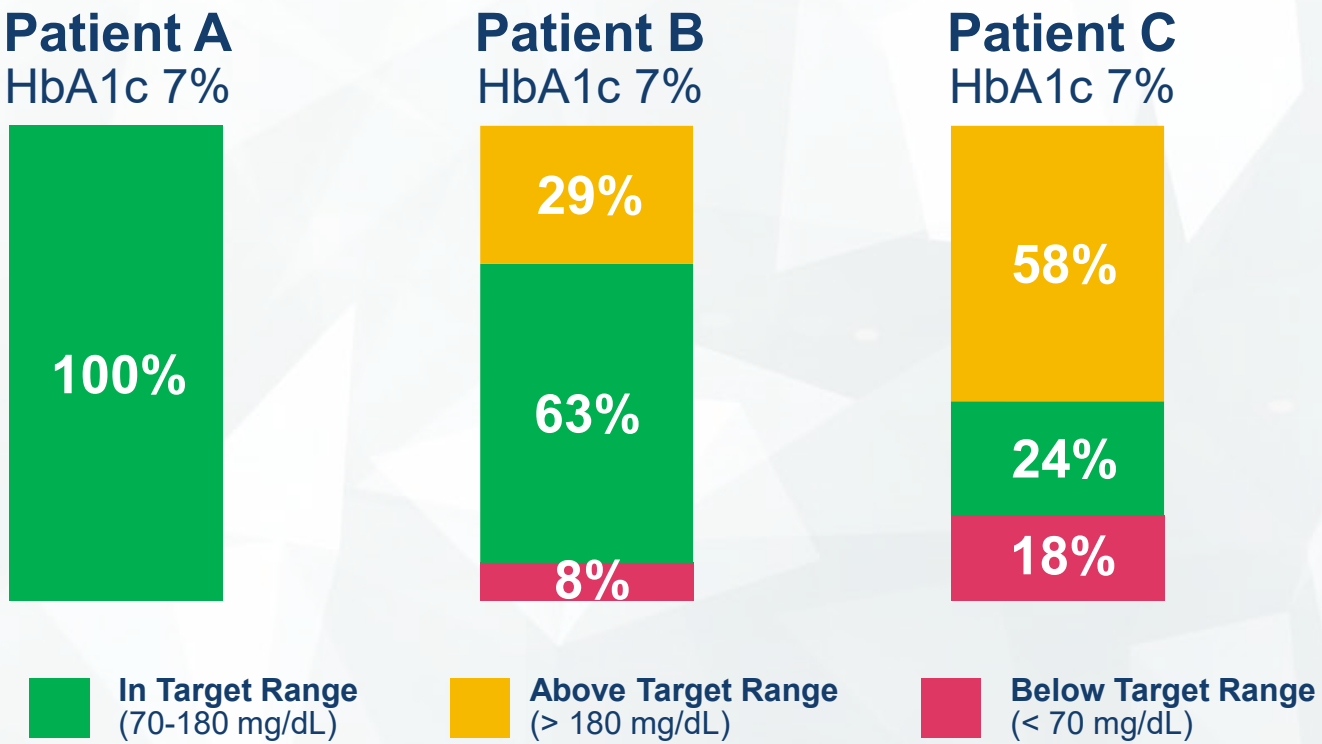
A1C, glycated hemoglobin or HbA1C; T2D, type 2 diabetes.

Laiteerapon N, et al. *Diabetes Care.* 2019.

A1C Values DO NOT EQUAL Time in Range (TIR)



A1C provides only an average of a patient's glucose history.

TIR provides more actionable information than A1C alone and should complement A1C.

Each 5% increase in TIR is clinically beneficial.

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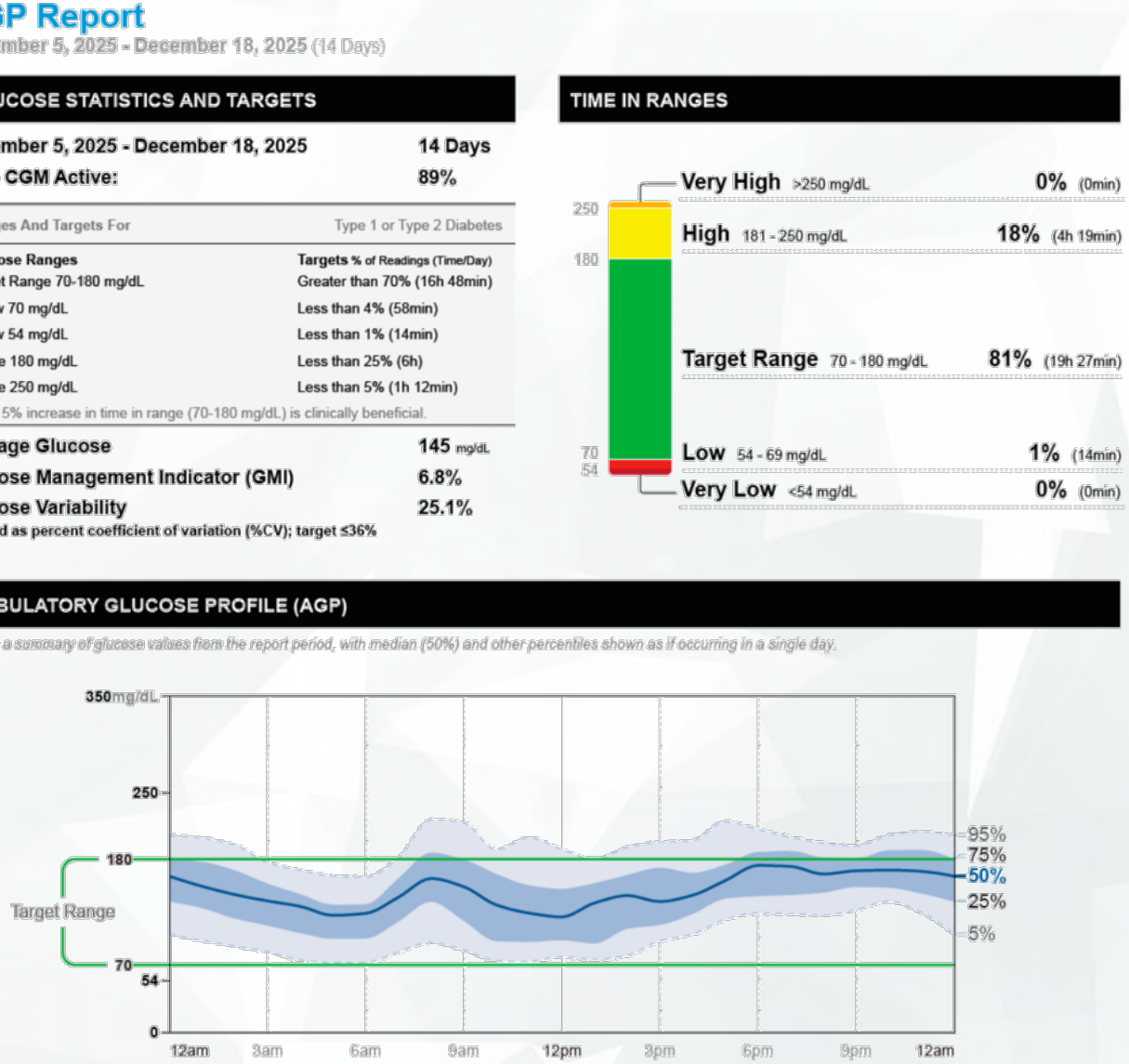
Not actual patient data- for illustrative purposes only.
Battelino T, et al. *Diabetes Care*. 2019.



Metrics reported in the AGP:

Glucose Statistics & Targets:

- Number of days the sensor is active:
  - recommended minimum 14 consecutive days
- Percentage of sensor data captured:
  - recommended minimum is 70%
- Glucose management indicator (GMI):
  - assesses glycemic control for the time covered
  - often used as an A1c comparison
- Glucose variability:
  - variance in glucose measurements
  - Goal: less than or equal to 36%
- Time above target glucose range (TAR) percentage of above a certain threshold
  - (e.g., 180 mg/dL [High] or 250 mg/dL [Very high])
- Time in range (TIR): percentage of time between 70 and 180 (goal: 70%)
- Time below target glucose range (TBR):
  - percentage of below a certain threshold
  - (e.g., 70 mg/dL [Low] or 54 mg/dL [Very low])

Ambulatory Glucose Profile:

- A summary of glucose value over the entire Report period, shown as though all values occurred in a single day.

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Battelino T, et al. *Diabetes Care*. 2019.

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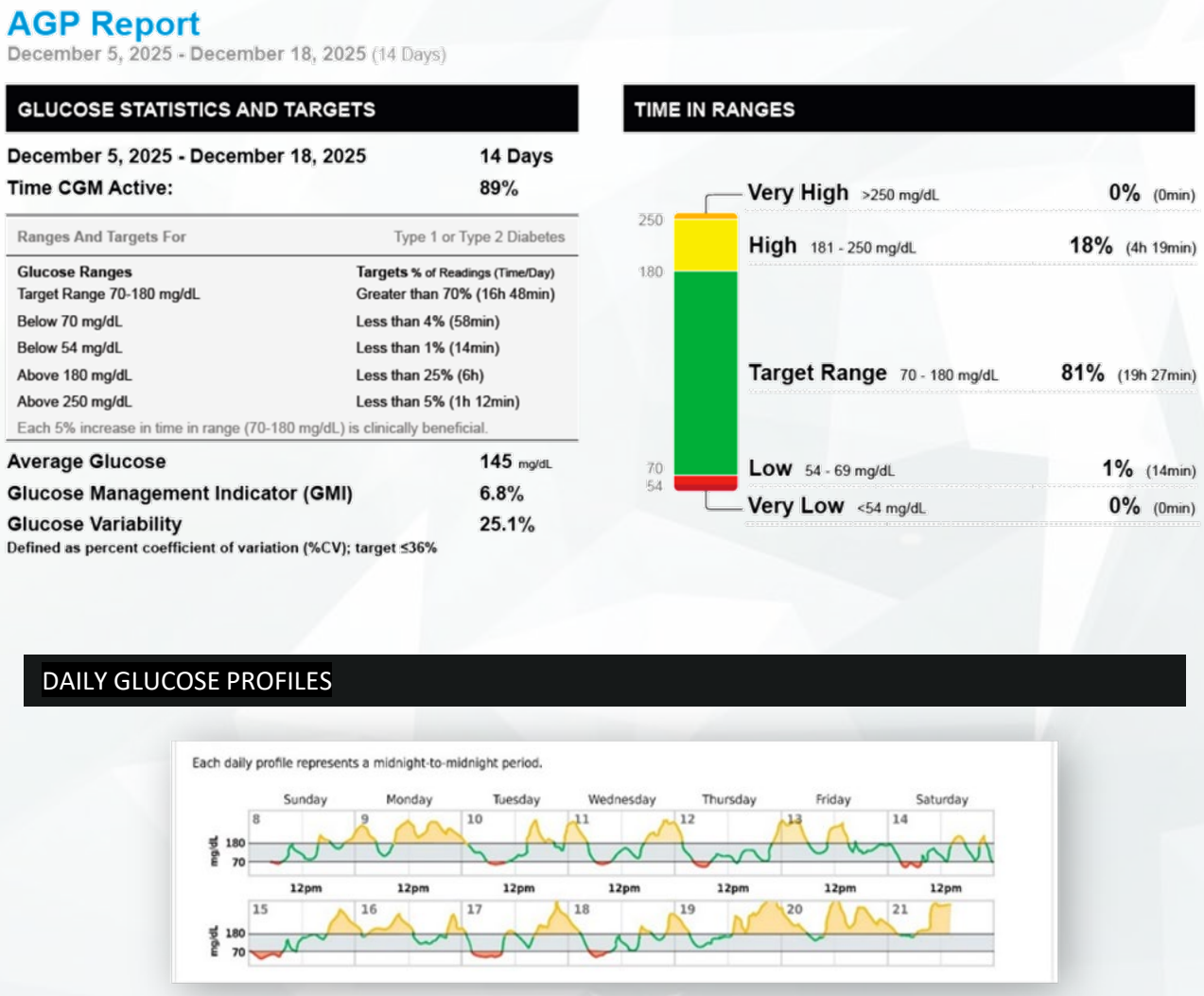

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Battelino T, et al. *Diabetes Care*. 2019.

Identifying Candidates for CGM

- ≥2 years of age who need or want more engagement with their diabetes
- At risk for hypoglycemia
  (e.g., patients of younger or older age, patients taking insulin)
- Need modification of current treatment or are experiencing clinical inertia
- Have poorly managed diabetes and would benefit from greater understanding of diet, activity, and medication on glycemic management
- Want to actively participate in their diabetes care, including making lifestyle changes

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Interprofessional Team Overview

- Team-based approach is important for patient care
- Limited time makes patient education challenging, even for specialists
- Multiple resources are available
  - Online and in-person
- Education should cover both device use and interpreting data
- Use available support systems to help patients
- Goal is patient comfort with CGM and maximizing its benefit

Key Takeaways

- CGM brings value to both clinicians and patients
- With updates to standards of care and reimbursement, ALL patients should be offered CGM