



Managed Care Perspectives on Achieving Diabetes Treatment Goals Using New Monitoring Technology

Tuesday, April 14th – 11:30AM CT – Room 104AB
Music City Center, Nashville TN



Presented by Cornerstone Medical Education, LLC.
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This event is held in
conjunction with



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- This activity provides 1.5 ACPE contact hours (0.15 CEUs) of continuing education credit. Universal Activity Number JA4008191-9999-26-022-L04-P. Knowledge.

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- Other members of the care team will receive a certificate of participation.



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Faculty & Planner/Reviewer Disclosures



- **Susan Cornell, PharmD, CDCES, FADCES**
 - **Advisory Board/Consultant:** Novo Nordisk
- **Jane Seley, DNP, MPH, MSN, GNP, BC-ADM, CDCES, FADCES**
 - Reports no relevant disclosures
- **Curtis Triplitt, PharmD, FADCES**
 - **Speaker's Bureau:** Novo Nordisk
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Activity Website



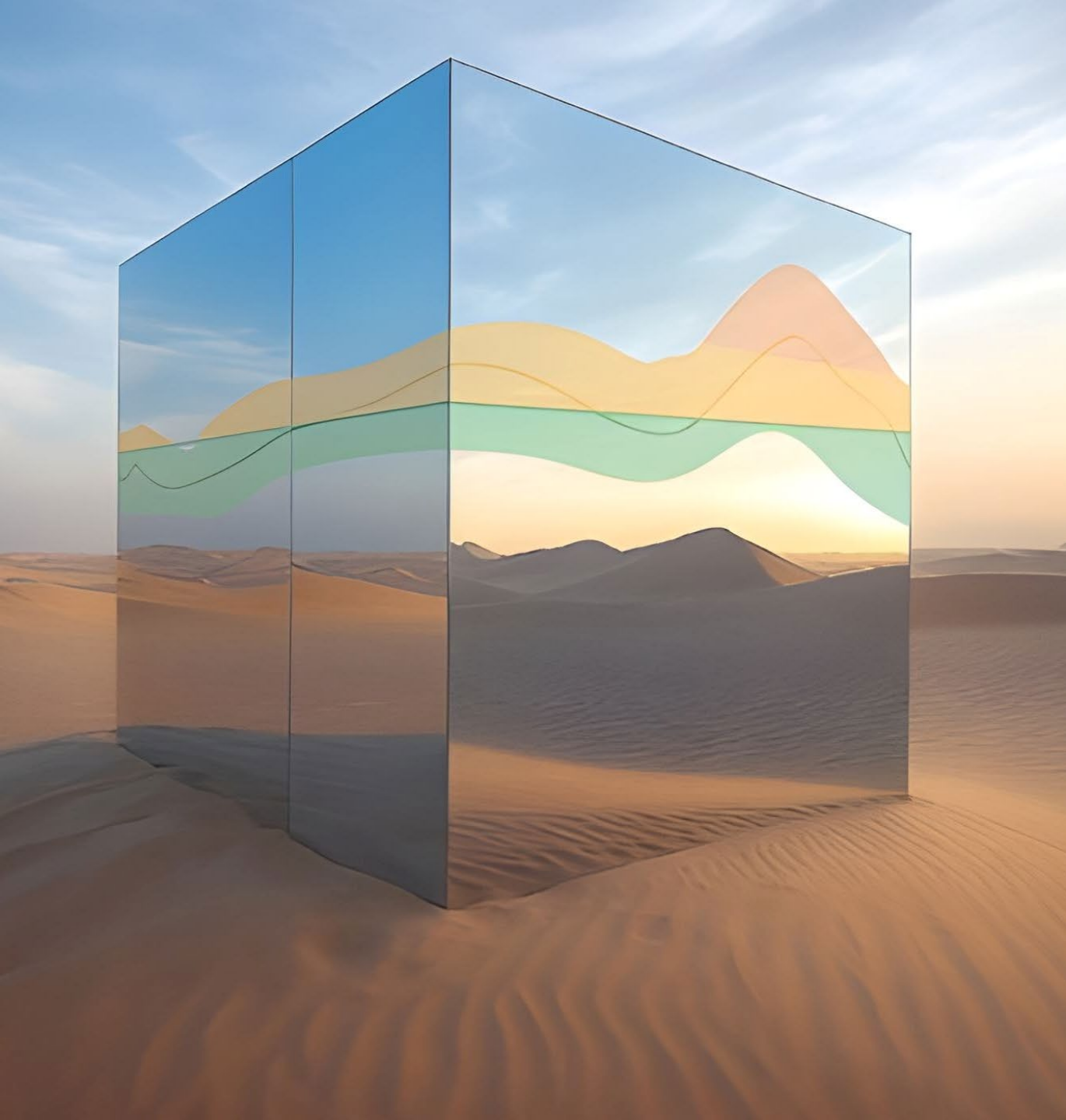
Access the Activity Website using this QR code (or by visiting https://cornerstonemeded.com/educational-programs/2026_amcp-diabetes-monitoring/)

Activity Slides, Bibliography & Suggested Reading, and CME Information are all available via (free) PDF Download

Learning Objectives



- **Review** the most recent updates to diabetes-related quality metrics.
- **Examine** the role of continuous monitoring in meeting diabetes quality metrics and improving patient outcomes.
- **Evaluate** data supporting the cost-effective use of advances in diabetes monitoring to improve patient outcomes.
- **Assess** diabetes monitoring utilization in practice via real-world patient case scenarios.



Activity Pre-Test



Pre-Test Question 1



Recent updates to diabetes quality measures now include which of the following as a clinician-level performance metric?

- A. Continuous glucose monitoring (CGM) utilization
- B. Insulin pump utilization only
- C. Continuous blood pressure monitoring
- D. Genetic testing for diabetes

Pre-Test Question 2



Which of the following best describes how continuous glucose monitoring (CGM) supports achievement of diabetes quality metrics?

- A. Replaces the need for HbA1c testing in all patients
- B. Provides real-time glucose data to improve glycemic assessment and clinical decision-making
- C. Eliminates the need for routine complication screening
- D. Primarily improves blood pressure control independent of glycemia

Pre-Test Question 3



Which combination of findings supports the conclusion that real-time CGM (RT-CGM) is cost-effective?

- A. A1c reduction of -0.3% and no QALY gain
- B. A1c reduction of -1.1%, QALY gain of 0.763
- C. Increased costs with no clinical benefit
- D. ICER exceeding \$150,000 per QALY

Pre-Test Question 4



A 58-yo patient with T2D has an HbA1c of 9.2% despite oral therapy. They report inconsistent self-monitoring of blood glucose (SMBG) and difficulty identifying glucose patterns. What is the most appropriate next step to optimize diabetes monitoring?

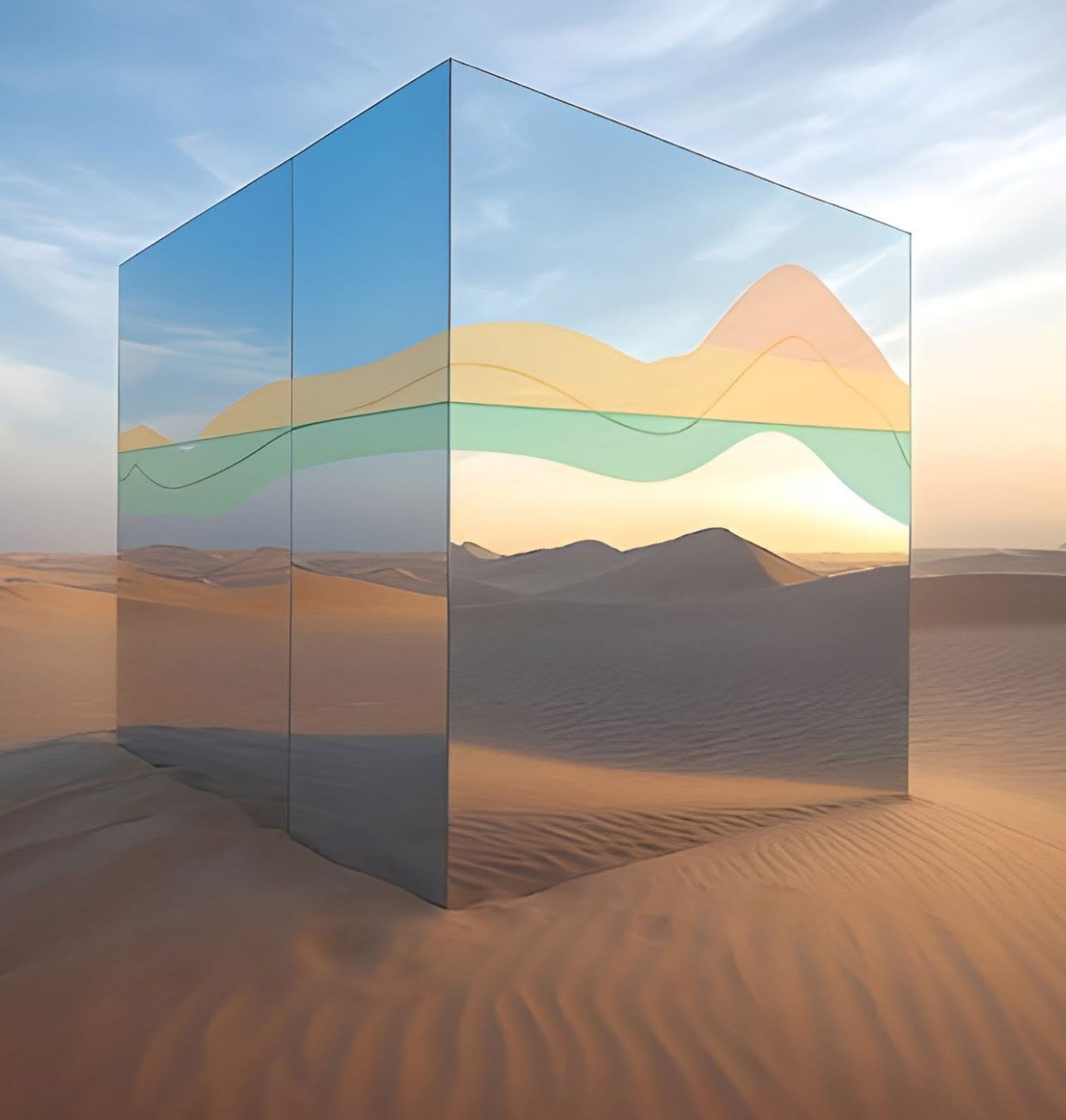
- A. Continue current SMBG without changes
- B. Discontinue glucose monitoring
- C. Focus only on annual HbA1c monitoring
- D. Initiate RT-CGM to assess glucose patterns and guide therapy

Pre-Test Question 5



How confident are you in your practical understanding of the benefits of CGM related to patient outcomes, cost-efficiency, and clinician performance?

- A. Extremely confident
- B. Very confident
- C. Moderately confident
- D. Slightly confident
- E. Not confident



The ABCs of CGM

*Managed Care Viewpoints
in a Value-Based Clinical
Infrastructure*



**Susan Cornell,
PharmD, FADCES**

Diabetes – The Scope of the Problem



- **Prevalence:**

- 40.1 million Americans, or 12% of the population
 - 39.8 million adults
- 2.1 million Americans have type 1 diabetes
 - ~ 314,000 children and adolescents
 - ~40% of adults with type 1 diabetes are misdiagnosed with type 2 diabetes

- **Prevalence in seniors:**

- People ≥ 65 account for 28.8%

- **Prediabetes:**

- 115.2 million Americans age 18 and older have prediabetes
 - 31.3 million adults ≥ 65 years old



CDC. National Diabetes Statistics Report. January 21, 2026.

Diabetes Quality Metrics – NCQA



The National Committee for Quality Assurance (NCQA) *Diabetes Recognition Program* measures clinician-level performance in the following areas:

- Glycemic Status Assessment <8.0%
- Glycemic Status Assessment >9.0%
- Blood Pressure Control <140/90 mmHg
- Eye Examination
- Statin Therapy Prescription
- Foot Examination
- Kidney Health Evaluation
- Smoking and Tobacco Use Screening and Follow-Up
- Depression Screening and Follow-Up
- Continuous Glucose Monitoring Utilization



NCQA website. Diabetes Recognition Program. 2026.



Where Technology Meets Quality

How does innovative technology, such as continuous monitoring, help clinicians and health-systems achieve these quality metrics?

- Glycemic Status Assessment <8.0%
- Glycemic Status Assessment >9.0%
- Blood Pressure Control <140/90 mmHg
- Eye Examination
- Statin Therapy Prescription
- Foot Examination
- Kidney Health Evaluation
- Smoking and Tobacco Use Screening and Follow-Up
- Depression Screening and Follow-Up
- Continuous Glucose Monitoring (CGM) Utilization
 - *Slated to become a new HEDIS measure in 2026*
 - *Vital component of glycemic status assessment, including GMI and real-time monitoring capacity*

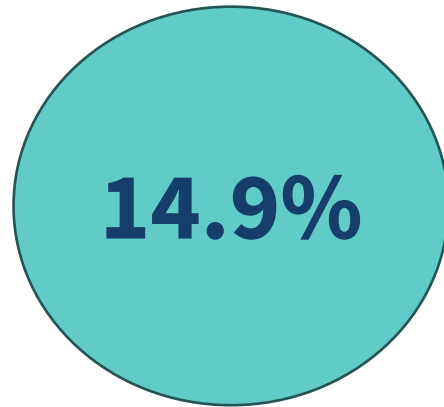


NCQA website. Diabetes Recognition Program. 2026; ADA Standards of Care in Diabetes. Diabetes Technology. 2026; NCQA website. HEDIS and Performance Measurement. 2026; Morris-Murray M, Frazzitta M. *J Manag Care Spec Pharm.* 2024.

HEDIS, Healthcare Effectiveness Data and Information Set; GMI, glucose management indicator

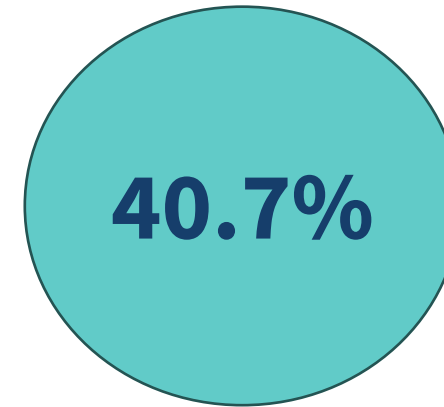


A (Big) Practice Gap



- **Met all these criteria:**

- A1c value <7.0%,
- Blood pressure <130/80 mmHg
- Non-HDL cholesterol <130 mg/dL



- **Met all these criteria:**

- A1c value <8.0%,
- Blood pressure <140/90 mmHg
- Non-HDL cholesterol <160 mg/dL

A1c, glycosylated hemoglobin; Note: these metrics only included non-smokers, so the gap is likely even larger

CDC. National Diabetes Statistics Report. January 21, 2026.

Audience Response Question

Which of the following statements is true regarding the A1c metric?

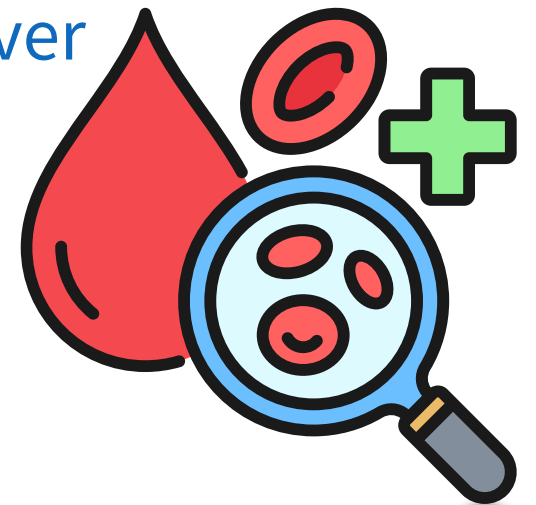
- A. Accurately measures glycemic variability**
- B. Can be affected by some anemias**
- C. Correctly measures occurrences or frequency of hypoglycemia**
- D. Is accurate in end-stage kidney disease**





A1c Limitations

- Does not measure glycemic variability
- Does not measure occurrences or frequency of hypoglycemia
- Can be affected by conditions with red blood cell turnover
 - Some anemias (e.g., iron deficiency, sickle cell, etc.)
 - Glucose-6-phosphate dehydrogenase deficiency
 - Recent blood transfusion
 - Drugs that stimulate erythropoiesis
 - End-stage kidney disease
 - Pregnancy



ADA Standards of Care in Diabetes. Diagnosis and Classification of Diabetes. 2026.



Types of CGM Devices

CGM measures interstitial glucose and correlates well with plasma glucose. However, CGM can lag if glucose levels are rising or falling rapidly.

Type of CGM	Brand	Availability	Alarms	Use in Pregnancy
Real time (rtCGM) <i>Device owned by user</i>	Libre 2 Plus / Libre 3 Plus	Prescription	Yes	Yes (both)
	Dexcom G6 and G7	Prescription	Yes	Yes (G7)
	Eversense 365	Prescription	Yes	
	Guardian 4	Prescription	Yes	
	Simplera	Prescription	Yes	
OTC-CGM <i>Device owned by user</i>	Dexcom Stelo	OTC	No	
	Abbott Lingo	OTC	No	
Professional CGM <i>Device owned by the practice/clinic</i>	Dexcom G6 Pro	In office	No	

Adapted from ADA Standards of Care in Diabetes. Diabetes Technology. 2026; FDA Prescribing Information.

CGM Goals

TAR = time above range
 TIR = time in range
 TBR = time below range



Diabetes Type	Glucose Range		Recommendations (% of readings; time per day)
Type 1/type 2 diabetes	<54 mg/dL	TBR level 2	<1% (<15 min)
	<70 mg/dL	TBR level 1	<4% (<1 h)
	70-180 mg/dL	TIR	>70% (>16 h, 48 min) >60% for individuals <25 years old (>14 h, 24 min)
	>180 mg/dL	TAR level 1	<25% (<6 h)
	>250 mg/dL	TAR level 2	<5% (<1 h, 12 min)
Older/high-risk Type 1/Type 2	<70 mg/dL	TBR	<1% (<15 min)
	70-180 mg/dL	TIR	>50% (>12 h)
	>250 mg/dL	TAR	<10% (<2 h, 24 min)
Pregnancy with Type 1	<54 mg/dL	TBR level 1	<1% (<15 min)
	<63 mg/dL	TBR level 2	<4% (<1 h)
	63-140 mg/dL	TIR	>70% (>16 h, 48 min)
	>140 mg/dL	TAR	<25% (<6 h)

ADA Standards of Care in Diabetes. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises. 2026.

Relationship Between A1c, Blood Glucose, and Time-in-Range (70-180 mg/dL)



A1C (%)	Estimated Average BG (mg/dL)
6.5	140
7.0	154
7.5	169
8.0	183
8.5	197
9.0	212
9.5	226
10	240

TIR of 50% corresponds approximately to a GMI of 8%

TIR (%)	Glucose Management Indicator (%)
40	8.4-9.0
50	7.9-8.3
60	7.4-7.5
70	6.7-7.0
80	6.9-6.5

BG, blood glucose; TIR, time-in-range; GMI, glucose management indicator

Selvin E. *Diabetes Care*. 2024; Battelino T, et al. *Diabetes Care*. 2019; Beck RW, et al. *Diabetes Technol Ther*. 2024.

AGP Report: Glucose Statistics and TIR



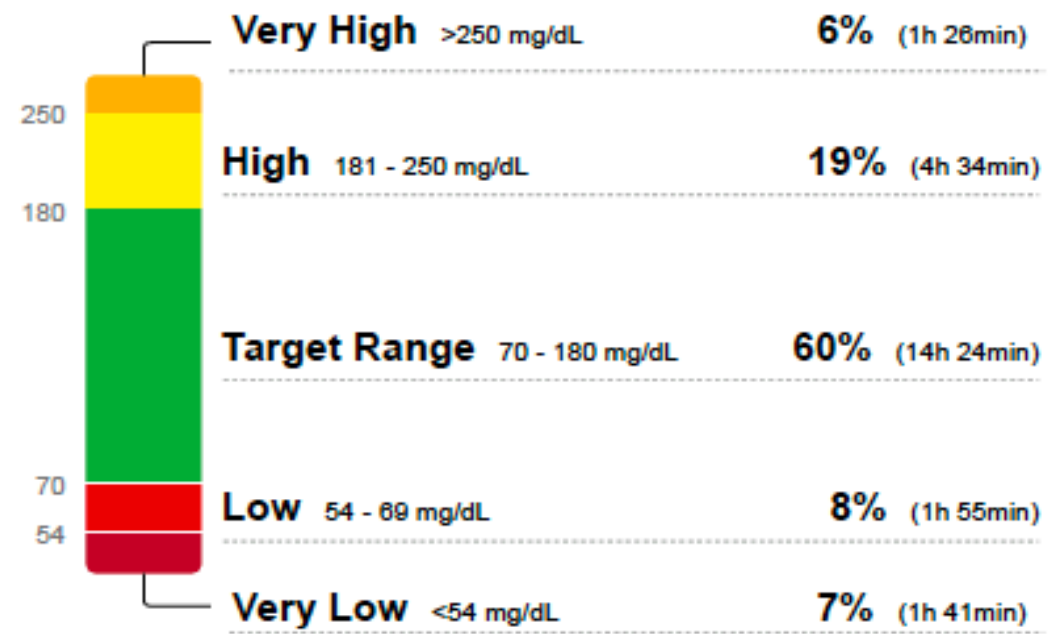
GLUCOSE STATISTICS AND TARGETS

March 2, 2022 - March 15, 2022 **14 Days**
% Time CGM is Active **92%**

Ranges And Targets For	Type 1 or Type 2 Diabetes
Glucose Ranges	Targets % of Readings (Time/Day)
Target Range 70-180 mg/dL	Greater than 70% (16h 48min)
Below 70 mg/dL	Less than 4% (58min)
Below 54 mg/dL	Less than 1% (14min)
Above 180 mg/dL	Less than 25% (6h)
Above 250 mg/dL	Less than 5% (1h 12min)
Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.	

Average Glucose **139 mg/dL**
Glucose Management Indicator (GMI) **6.6%**
Glucose Variability **45.8%**
 Defined as percent coefficient of variation (%CV); target ≤36%

TIME IN RANGES



AGP, ambulatory glucose profile

Selvin E. *Diabetes Care*. 2024; ADA Standards of Care in Diabetes. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises. 2026; ADA Standards of Care in Diabetes. Diabetes Technology. 2026.



Interpreting the AGP Report

1- CGM active

4- Hyperglycemic events

AGP Report

January 16, 2025 - January 29, 2025 (14 Days)

GLUCOSE STATISTICS AND TARGETS

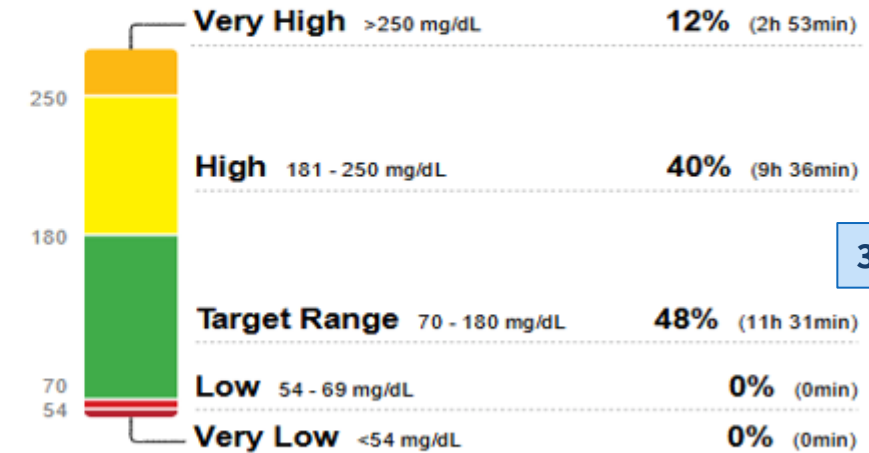
January 16, 2025 - January 29, 2025 **14 Days**
Time CGM Active: **98%**

Ranges And Targets For	Type 1 or Type 2 Diabetes
Glucose Ranges	Targets % of Readings (Time/Day)
Target Range 70-180 mg/dL	Greater than 70% (16h 48min)
Below 70 mg/dL	Less than 4% (58min)
Below 54 mg/dL	Less than 1% (14min)
Above 180 mg/dL	Less than 25% (6h)
Above 250 mg/dL	Less than 5% (1h 12min)

Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.

Average Glucose **194** mg/dL
Glucose Management Indicator (GMI) **8.0%**
Glucose Variability **21.1%**
Defined as percent coefficient of variation (%CV); target ≤36%

TIME IN RANGES



3- Time in range

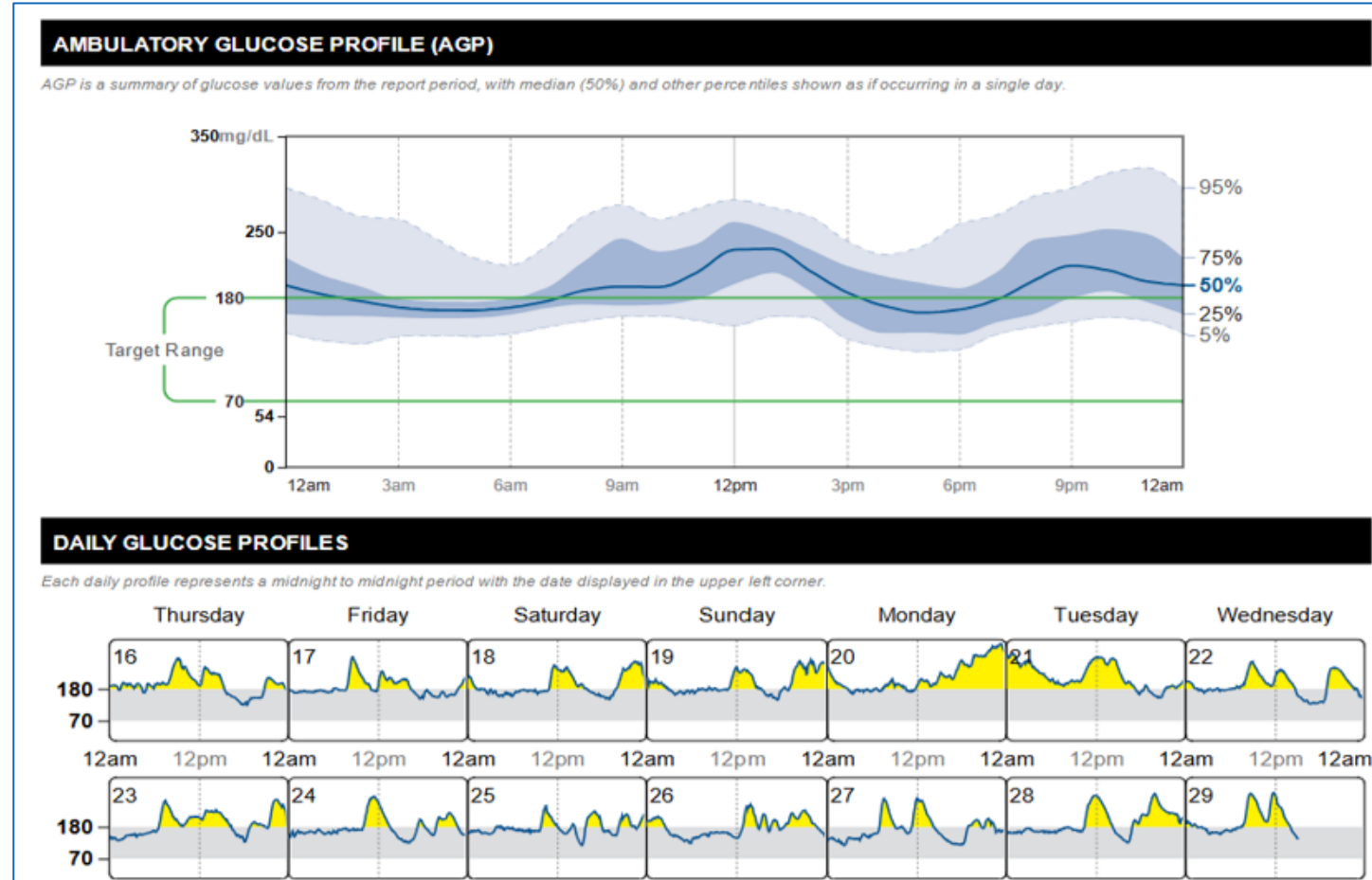
5- Glucose Variability

2- Hypoglycemic events

Battelino T, et al. *Diabetes Care*. 2019; ADA Standards of Care in Diabetes. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises. 2026; ADA Standards of Care in Diabetes. Diabetes Technology. 2026.



Interpreting the AGP Report



6- Median curve

7- Daily profiles

Battelino T, et al. *Diabetes Care*. 2019; ADA Standards of Care in Diabetes. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises. 2026; ADA Standards of Care in Diabetes. Diabetes Technology. 2026.

Benefits of CGM



- **Type 1 diabetes:**

- Increased TIR relates to risk of complications
- Clinical trial results show CGM can reduce:
 - A1C
 - Hypoglycemic episodes
 - Diabetic ketoacidosis (DKA)
 - All-cause hospitalizations
 - Rates of emergency department visits
 - Rates of hospitalization for hypoglycemia

- **Type 2 diabetes:**

- Using basal insulin:
 - Decrease in acute diabetes related events
 - Decrease in all-cause hospitalizations
 - Increased treatment satisfaction
- Not using insulin:
 - Decreased A1c levels
 - Increased TIR
 - Decreased time in hyperglycemia

CGM News



- **Burgeoning evidence in support of CGM improving glycemic outcomes—and cost efficiency – in T2D treated with non-insulin therapies**
- **Clinical event rates and healthcare resource utilization (HCRU)**
 - Over 12 months, CGM reduced hospitalizations (-25%), ED visits (7%), DKA (-86%), and acute diabetes complications (-7%) – $P < 0.0001$ for all
 - Significant reductions in overarching HCRU
- **Cost-effectiveness and impacts on diabetes care quality**
 - Improved A1c reduction with RT-CGM vs. SMBG (-1.1% vs. -0.3%, respectively)
 - Quality-adjusted life years (QALYs) gained with CGM = 0.763
 - CGM incremental cost-effectiveness ratio (ICER) = 40,349 per QALY gained
 - *RT-CGM is cost-effective/cost-saving for payors*

DKA, diabetic ketoacidosis; SMBG, self-monitored blood glucose

Alshannaq H, et al. *J Manag Care Spec Pharm.* 2025; Sharma A, et al. *Diabetes Technol Ther.* 2026.



Let's Meet Chris

Case #1

Chris (54 years old)



Chris is a finance manager at a large company

- Eats 3 healthy meals daily and avoids snacking
- Drinks 2-3 cups of coffee daily
- 1-2 glasses of wine on weekends
- Denies smoking/vaping/cannabis use
- Insurance with prescription coverage for most diabetes medications/devices

Medical History/Current Medications:

- T2D Metformin 1000 mg twice daily
 Insulin glargine U-100 – 30 units daily
- Hypertension Lisinopril/HCTZ 10 mg/12.5 mg daily
- Dyslipidemia Atorvastatin 40 mg daily

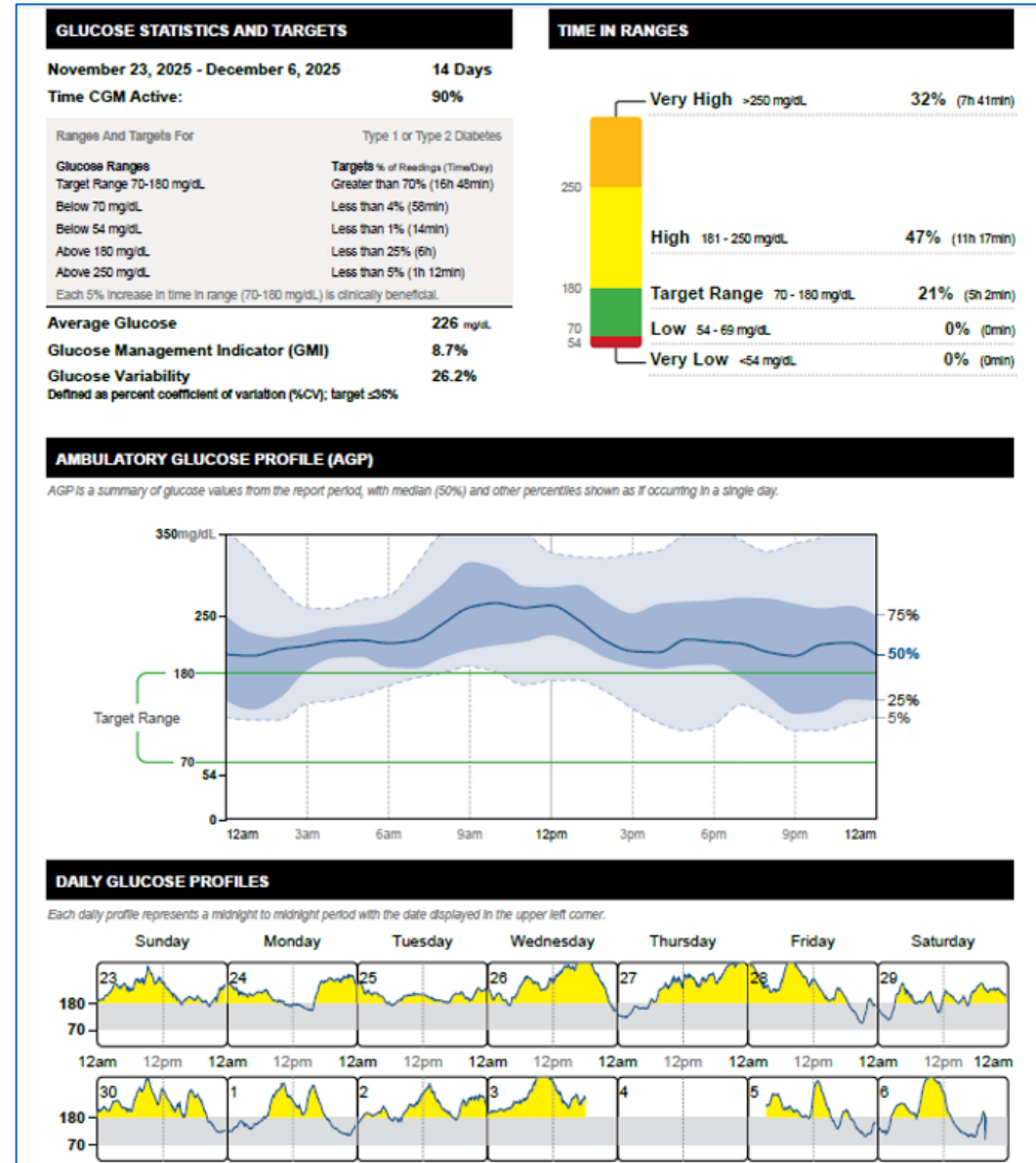
	Today
Height	5 ft 10 in
Weight	234 lbs
Blood pressure (sitting)	124/78 mm Hg
Heart rate	58 bpm
FPG	205 mg/dL
A1C	8.5%
LDL	108 mg/dL
HDL	40 mg/dL
TG	175 mg/dL
eGFR	>84 mL/min/1.73 m ²
UACR	45 mg/g



Chris's AGP Report

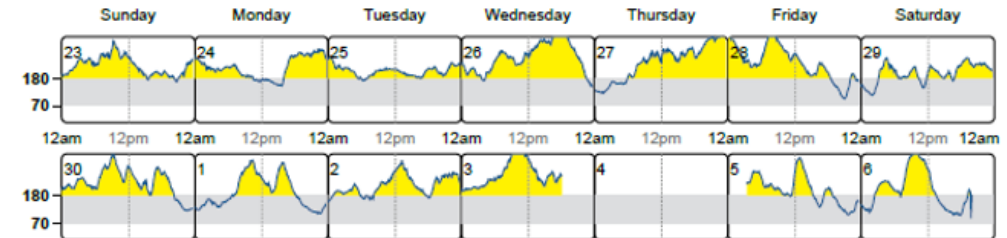


What pattern(s) do you see?
Is an intervention needed?



DAILY GLUCOSE PROFILES

Each daily profile represents a midnight to midnight period with the date displayed in the upper left corner.



Audience Response Question



Chris's primary care clinician requests your recommendation regarding the management of Chris's diabetes therapy. What would you recommend?

- A. Continue metformin and increase insulin glargine to 32 units**
- B. Continue metformin and insulin glargine as is, and start empagliflozin 10 mg daily**
- C. Continue metformin, increase insulin glargine to 32 units and start semaglutide injection 0.25 mg once weekly and titrate to therapeutic dose**
- D. No medication change is needed at this time**

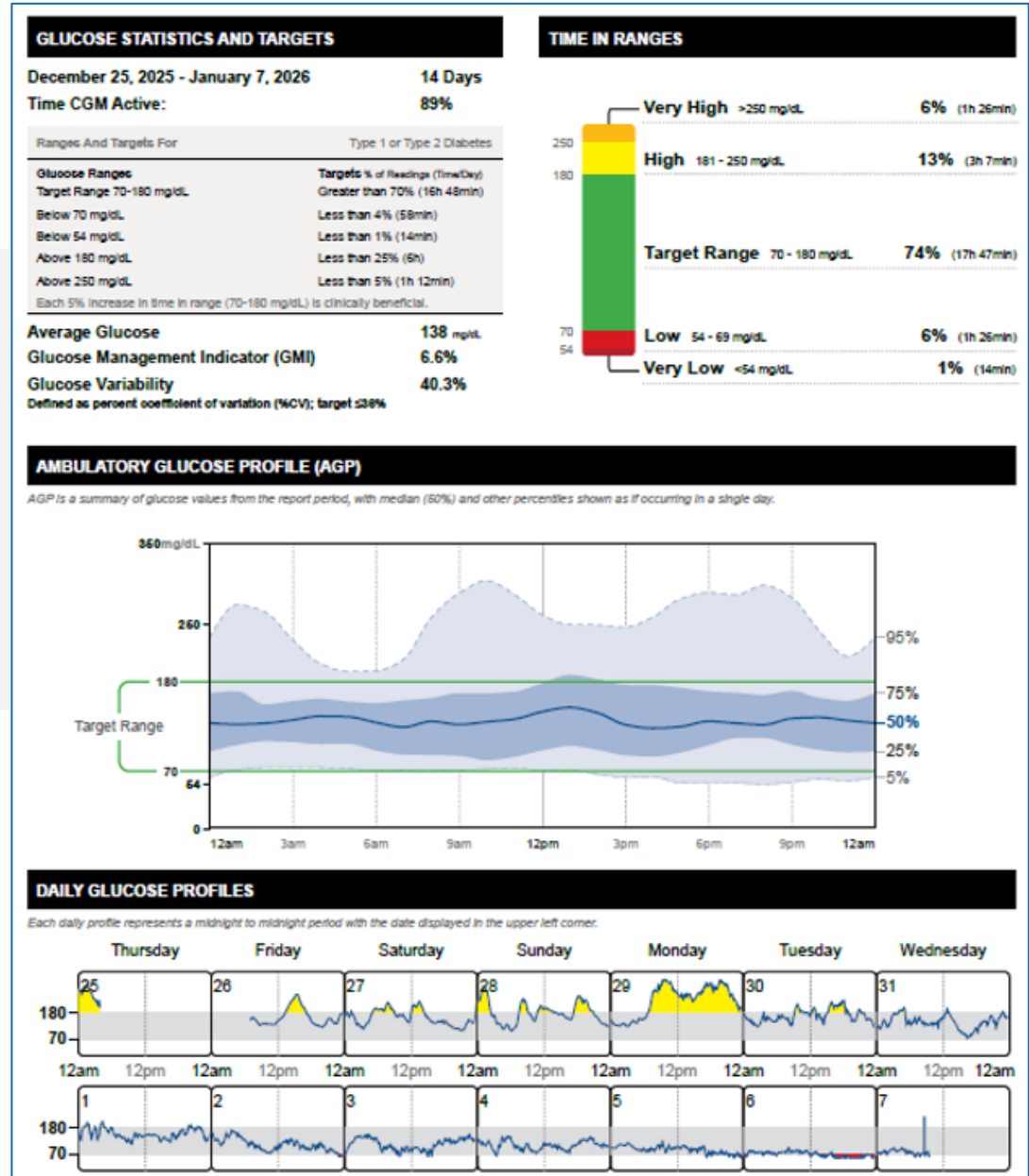


Chris – 2 Months Later

Medical History/Current Medications:

- T2D Metformin 1000 mg twice daily
 Insulin glargine U-100 – 32 units daily
 Semaglutide 0.5 mg once weekly
- Hypertension Lisinopril/HCTZ 10 mg/12.5 mg daily
- Dyslipidemia Atorvastatin 40 mg daily

	Today
Height	5 ft 10 in
Weight	210 lbs
Blood pressure (sitting)	118/74 mm Hg
Heart rate	68 bpm
FPG	112 mg/dL
A1C	7.1%



Discussion Topics – Chris’s Case



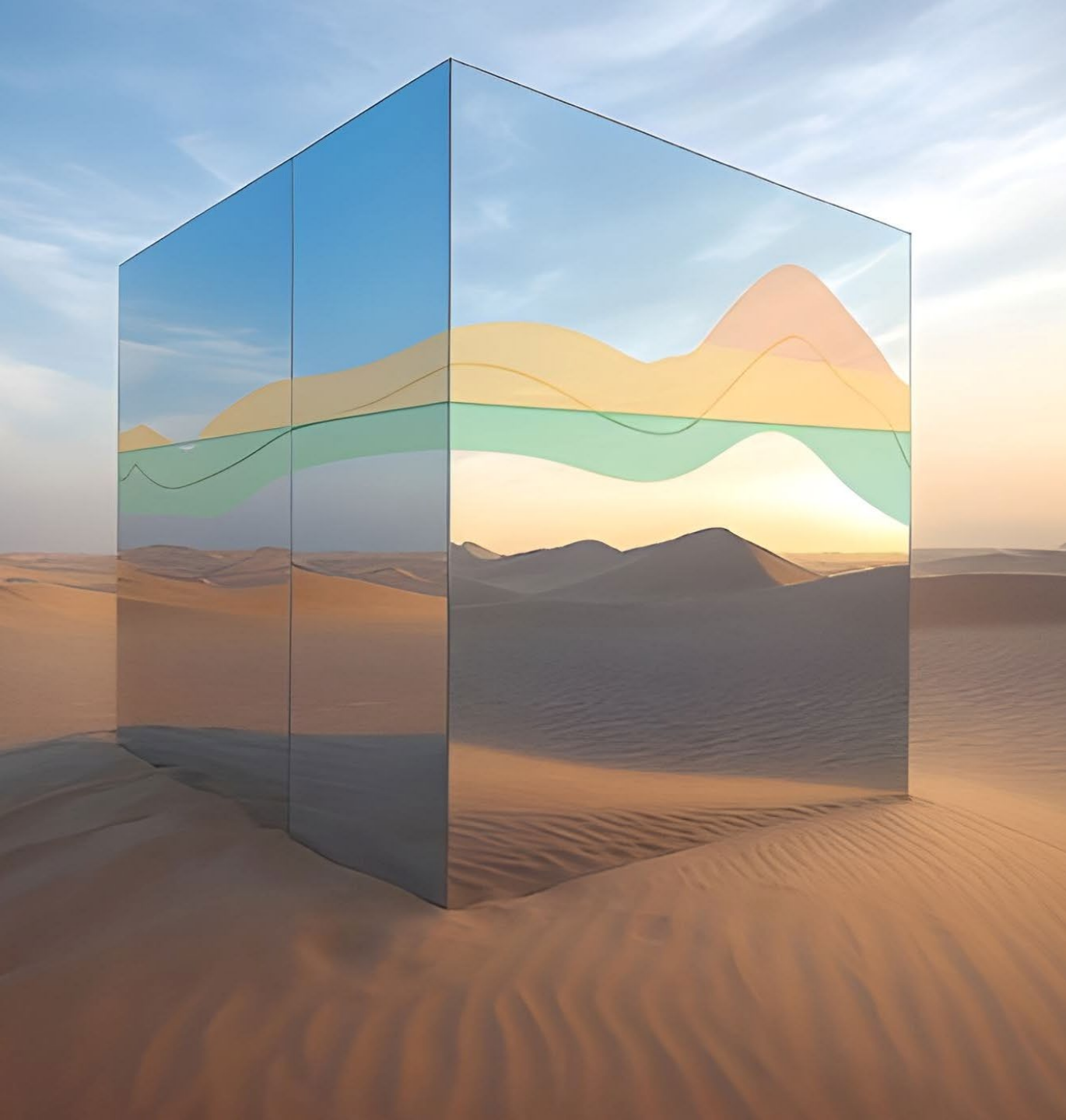
1. What questions you would ask Chris before making an assessment?
2. From a medication perspective, what medications (if any) would you add, change, or de-prescribe?
3. What nutrition/lifestyle recommendations would you recommend overall and to enhance the medication therapy effects and/or minimize/prevent side effects?





Let's pause for a digestion break

- *What are 1 to 2 concepts that have resonated with you so far?*
- *How can you apply these concepts to your pharmacy/managed care practice?*



Navigating the Diabetes Care Continuum

*A Review of CGM, Clinical
Nuances, and Ketones*



**Curtis Triplitt,
PharmD, FADCES**



Let's Meet Jose

Case #2

Jose (67 Years Old)



Jose is a retired mechanical engineer

- Recent dyspnea and fatigue
- His ejection fraction is 40%; new onset heart failure (HF)
- He has a CGM
- Denies smoking/vaping/cannabis use
- Insurance with prescription coverage for most diabetes medications/devices

Medical History/Current Medications:

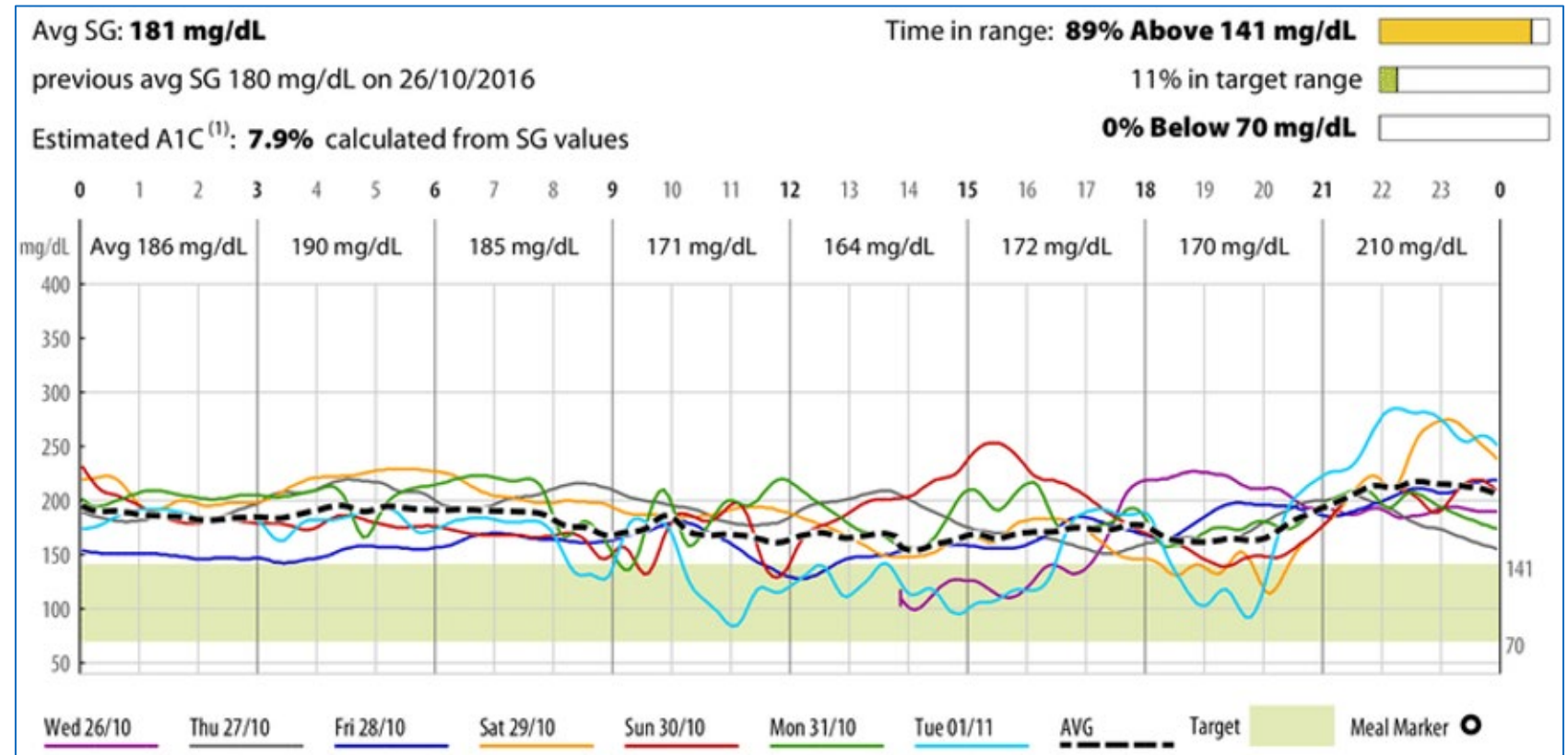
- T2D Metformin 1000 mg twice daily
 Insulin Degludec 62 units daily
- Hypertension Lisinopril 20mg daily, chlorthalidone
 25mg daily, carvedilol 25mg BID
- Dyslipidemia Rosuvastatin 10mg daily
- HF Empagliflozin 25mg daily (new)

	Today
BMI	31 kg/m ²
A1C	8.1%
Blood pressure (sitting)	134/88 mm Hg
Heart rate	67 bpm
FPG	182 mg/dL
A1C	8.5%
Lipids	At goal
eGFR	56 mL/min/1.73 m ²
UACR	85 mg/g

Jose's AGP Report



- Jose reports adherence to all his medications
- He states his glucose is not quite at goal; usually reads in the “high 100s”
- *His AGP is shown here* →



Jose Isn't Feeling Well



- Jose reports that he has been feeling more fatigued in the last several days and is worried he is coming down with the flu.
- He has stomach cramps, fatigue, and now is having a hard time keeping food down.

Lab Values

	Today
Glucose	210 mg/dL (H)
Serum Cr	1.7 mg/dL (H)
Anion gap	18 mEq/L (H)
Beta-hydroxybutyrate	4.7 mmol/L (H)

He calls to ask what you think he should do?

Diabetes & DKA: Impact of SGLT2 Inhibition



- **DKA risk with SGLT2 inhibitors in T1D is relatively high**
 - Note: SGLT2 inhibitors are NOT currently FDA approved for T1D
 - *SGLT2 inhibitor-associated DKA in people with T1D = ~4%*
 - *DKA risk ~5–17 times higher vs. people with T1D not treated with SGLT2 inhibitors*
- **DKA risk with SGLT2 inhibitors in T2D is relatively low**
 - Note: SGLT2 inhibitors ARE currently FDA approved for T2D
 - *Estimated incidence of 0.6–4.9 events per 1,000 patient-years*
 - *Meta-analysis studies have found excess relative risk of 1.74 to 2.46*

Jose (67 Years Old)



Jose is a retired mechanical engineer

- Recent dyspnea and fatigue
- His ejection fraction is 40%; new onset heart failure (HF)
- He has a CGM
- Denies smoking/vaping/cannabis use
- Insurance with prescription coverage for most diabetes medications/devices

Medical History/Current Medications:

- T2D Metformin 1000 mg twice daily
 Insulin Degludec 62 units daily
- Hypertension Lisinopril 20mg daily, chlorthalidone
 25mg daily, carvedilol 25mg twice daily
- Dyslipidemia Rosuvastatin 10mg daily
- HF Empagliflozin 25mg daily (new)

	Today
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UACR	85 mg/g

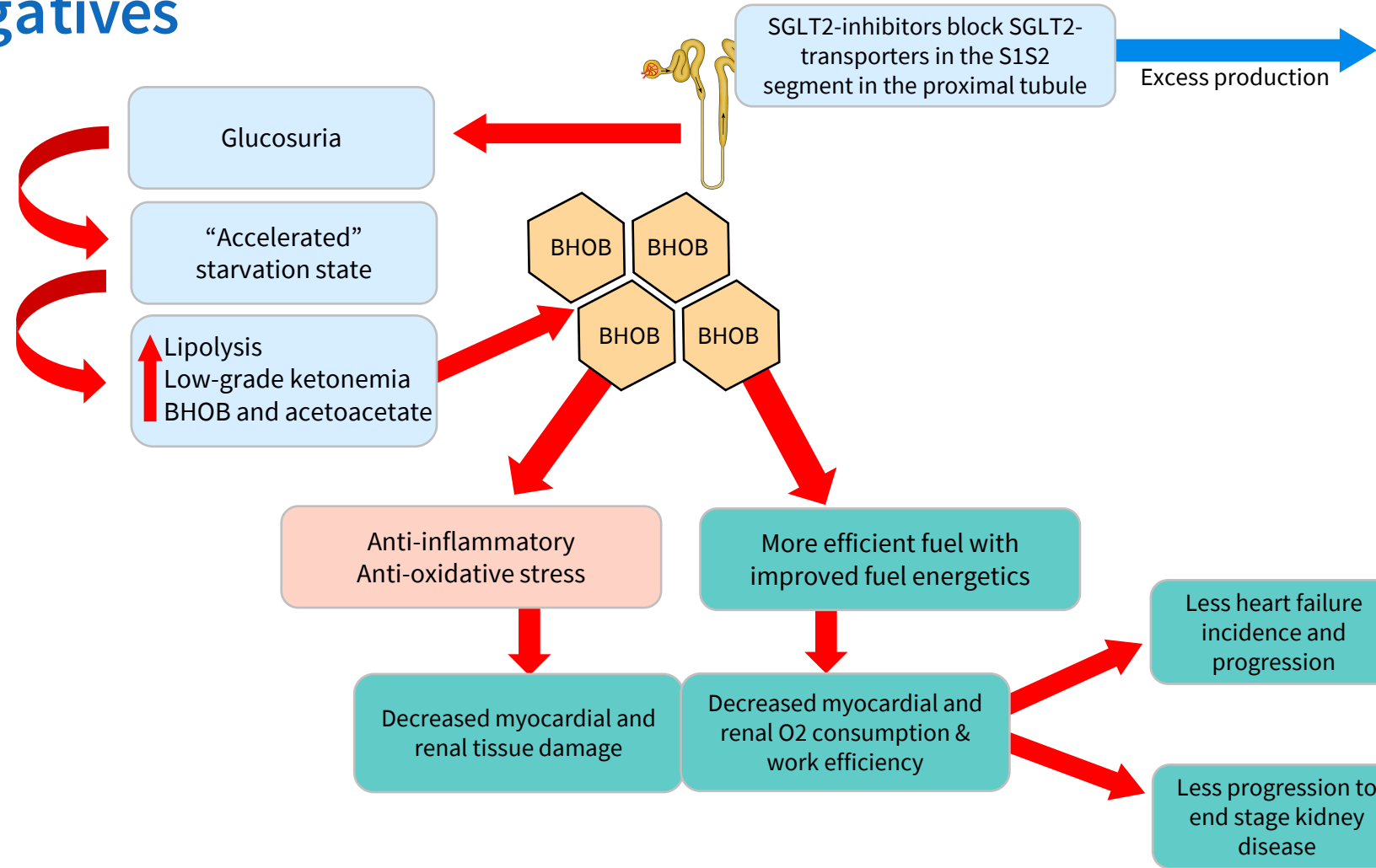
SGLT2 Inhibitors Induce Low-grade Ketonemia

Positives and Negatives



Risk of euDKA Increase:

- Dehydration
- Prolong fasting
- Very low CHO diet
- Excessive ETOH
- Autoimmune diabetes
- Insulin Deficient T2D



euDKA, euglycemic DKA; ETOH, ethanol

Ekanayake P, et al. *Diabetes Obes Metab.* 2022; Chow E, et al. *BMJ Open Diabetes Res Care.* 2023; Baek H, et al. *Diabetes Metab J.* 2024.

Audience Response Question



Why is a CGM limited in its ability to diagnose euglycemic DKA?

- A. Interstitial glucose is not accurate compared to blood**
- B. High creatinine causes false high glucose readings**
- C. SGLT2 inhibitors prevent glucose from increasing to normal DKA levels**
- D. CGM is not accurate if an SGLT2 inhibitor is being used**



When Blood Glucose Should be Checked While on CGM



Times to Check Blood Glucose	Reasoning
Warm-up period, sometimes up to 24hours	Occasional sensor inaccuracy early in use
“Compression low” from sleeping on sensor	“uncompress” sensor, recheck accuracy in ½ hour or more
Rapidly changing glucose	Lag in interstitial fluid glucose
Unexpected “high” or “low” CGM glucose	Confirm a blood glucose if CGM reading is not what is expected or if you feel “high” or ‘low’ BG
Select drugs	High dose acetaminophen Higher dose Vit. C Higher dose salicylates Hydroxyurea
Temperature Extremes	Effects on local blood flow

ADA Standards of Care in Diabetes. Diabetes Technology. 2026.

Current Assessment for Ketosis in the Outpatient Setting



	Blood Capillary Meter	Urine Analysis
What does it measure?	β -hydroxybutyrate	Acetoacetate
Method of measuring	Discrete values	Colorimetric test
Cost	Expensive	Relatively affordable



Nguyen KT, et al. *J Diabetes Sci Technol.* 2022.

When to Monitor Ketones



It is important to check ketones during acute illness!

Individuals at risk for DKA

- T1D
- T2D with SGLT2 inhibitor use

Unexplained hyperglycemia

- Particularly if BG >200 mg/dL
- With or without symptoms

Symptoms of ketosis

- Abdominal pain, nausea, vomiting

If sick or stressed

- Recommended every 4-6 hours

If pregnant and severely restricted carbohydrates



- Recommended to check fasting ketones (urine or blood)

ADA Standards of Care in Diabetes. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises. 2026; ADA Standards of Care in Diabetes: Management of Diabetes in Pregnancy. 2026; ADA Standards of Care in Diabetes. Diabetes Technology. 2026; Sacks DB, et al. *Diabetes Care*. 2023; Dhatariya K, et al. *Lancet Diabetes Endocrinol*. 2024.

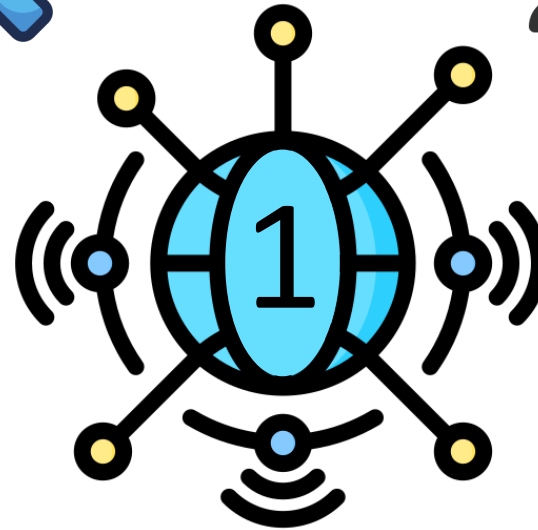


Continuous Ketone Monitoring (CKM)

Measurement of interstitial beta-hydroxybutyrate using a factory-calibrated CKM sensor



CKM sensors can identify changing ketone levels and flag significant changes to prevent or manage DKA



Ideal scenario: a single sensor that measures both CGM and ketones

Huang J, et al. *J Diabetes Sci Technol.* 2024.

Recommended CKM Users



Pregnant women living with diabetes

Individuals with recurrent DKA

Individuals taking medications that increase the risk of DKA

Individuals consuming very low-carbohydrate diets

Individuals participating in very high-intensity exercise

Socially or geographically isolated

Individuals fasting for procedures

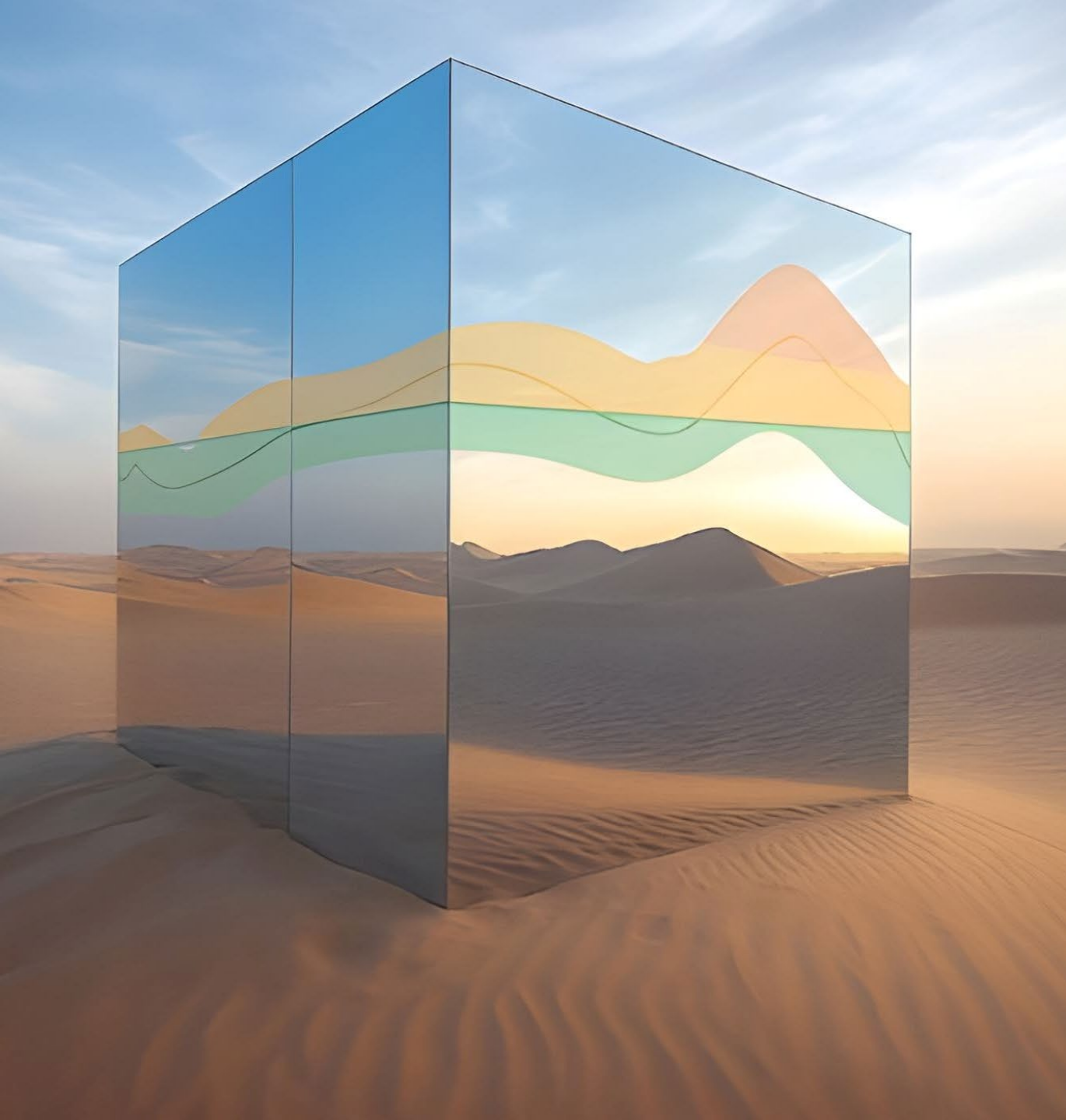
Individuals who are hospitalized/acutely ill

Kong YW, et al. *Diabetes Obes Metab.* 2024; Nguyen K, et al. *J Diab Sci Tech.* 2022.



Let's pause for a digestion break

- *What are 1 to 2 concepts that have resonated with you so far?*
- *How can you apply these concepts to your pharmacy/managed care practice?*



Role of CGM in the Inpatient Setting

*Safe and Effective Use from
Hospital to Home*



**Jane Seley, DNP,
MPH, MSN, GNP**

Electronic Clinical Quality Improvement (eCQI) – Hospital Harm



- **Severe hypoglycemia – Background:**

- Inpatient hypoglycemia is a severe adverse event which is associated with increased hospital costs and longer lengths of stay
- This measure focuses on severe hypoglycemia in the inpatient setting in adults 18 years or older who received insulin within the past 24 hours prior to the hypoglycemia episode
- Prevalence of severe hypoglycemia is estimated to be in 2-5% of all inpatients with diabetes
- According to the Office of the Inspector General, hypoglycemia is one of the top 5 adverse drug events
- CMS defines severe hypoglycemia as a blood glucose of <40 mg/dl
- The Vizient definition is <50 mg/dl

eCQI Resource Center website. Hospital Harm - Severe Hypoglycemia. May 6, 2025.

Electronic Clinical Quality Improvement (eCQI) – Hospital Harm



- **Severe hypoglycemia – Action Plan:**

- The American Diabetes Association (2026) Standard of Care section on Inpatient Diabetes Management recommends that hospitals establish a hypoglycemia management protocol that includes a structured plan for identifying, treating and preventing hypoglycemia
- Hypoglycemia episodes should be documented each time they occur and tracked to identify root causes and inform quality improvement initiatives
- Majority of inpatients that have a severe hypoglycemic episode of less than 40 mg/dl had an earlier hypoglycemia episode less than 70 mg/dl during the same hospital stay
- Daily care team reviews of blood glucose levels and subsequent insulin adjustments is a key preventative measure
- In addition, a fasting glucose of less than 100 mg/dl has been shown to be a strong predictor of hypoglycemia within the next 24 hours of hospitalization

eCQI Resource Center website. Hospital Harm - Severe Hypoglycemia. May 6, 2025; ADA Standards of Care in Diabetes. Diabetes Care in the Hospital. 2026; Flory JH, et al. *J Diabetes Sci Technol*. 2014.

Current Status of CGM Use in Hospitals



Audience Response Question



Stand-alone personal CGMs are approved for use in hospitals to:

- A. Dose insulin**
- B. Notify team of impending hypoglycemia**
- C. Treat hypoglycemia**
- D. B & C**



Hospital-Owned CGM



Consensus considerations and best practice points for use of CGM in hospital settings include:

1. Potential benefits of CGM in inpatients
2. Existing guidance for use in hospitals
3. Analytical and clinical evaluation of CGM systems performance
4. Staff training, clinical workflow, and hospital policies
5. Management of CGM systems from a quality assurance perspective
6. Integration of CGM data in the electronic health record (EHR)
7. Cost considerations for hospital CGM system use
8. Barriers to CGM system implementation in hospitals

Shaw JLV, et al. *Diabetes Care*. 2024; ADA Standards of Care in Diabetes. Diabetes Care in the Hospital. 2026.

Hospital-Owned CGM



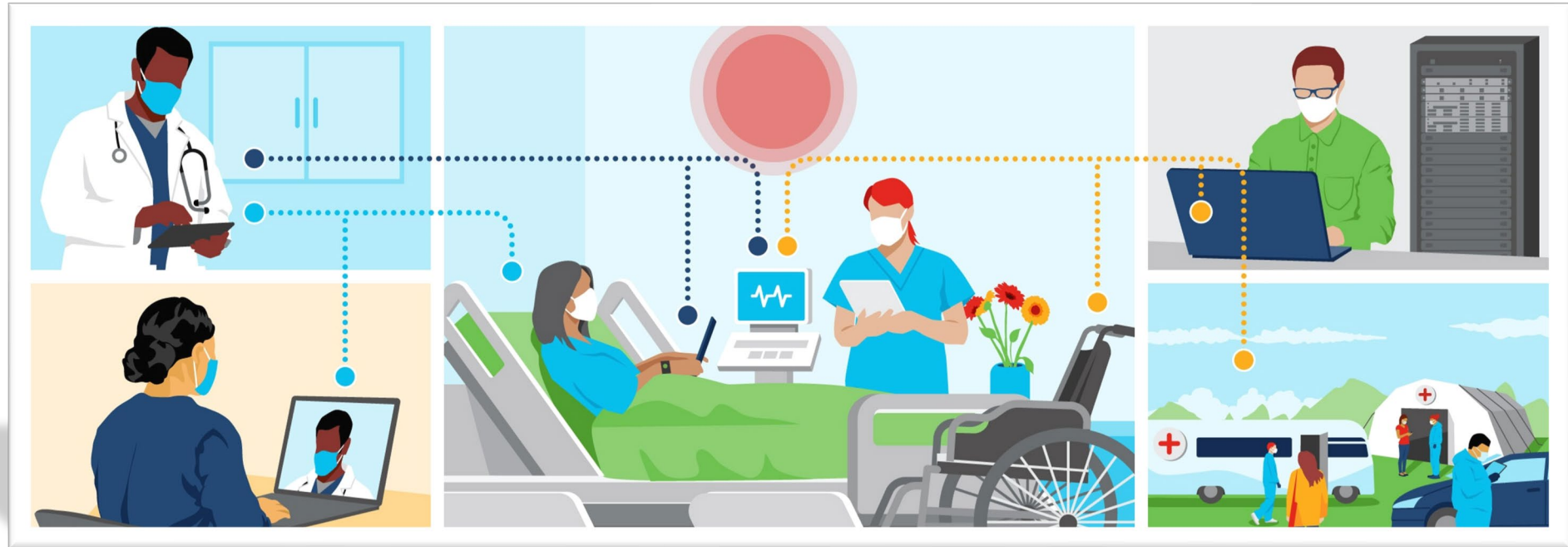
• Bottom Line Takeaways

- No CGM is currently approved for use in hospitals
- Researchers continue to study accuracy of CGMs in a variety of hospital settings and populations hoping to satisfy FDA requirements for clearance
- Personal CGMs should NOT be used to determine insulin doses or assess and treat hypoglycemia
- Personal CGMs SHOULD be used as an early warning system to prevent hypo- and hyperglycemia

Shaw JLV, et al. *Diabetes Care*. 2024; ADA Standards of Care in Diabetes. Diabetes Care in the Hospital. 2026.



Inpatient Tele-Consults



Inpatient Tele-Consults Via In-Room TV



- Offers clinicians remote access from any location to TV in patient room
- One click from the EHR record launches the encounter
- Facilitates training on BGM, CGM, and insulin delivery devices
- Available options are in compliance with regulatory standards such as the Securities Exchange Commission (SEC) and Health Insurance Portability and Accountability (HIPAA)



BGM, blood glucose monitoring

Finn E, et al. *Diabetes Care*. 2023; Olsen M, et al. *Diabetes Care*. 2025; Carlson A, et al. *Diabetes Technol Ther*. 2021; ADA Standards of Care in Diabetes. *Diabetes Care in the Hospital*. 2026.

Audience Response Question



A top candidate for receiving a personal CGM prior to hospital discharge is someone with:

- A. A1c >8% on oral agents**
- B. Hypoglycemia unawareness**
- C. Recurrent DKA**
- D. B & C**



Smooth Transition from Hospital to Home



Consider a CGM discharge program!

ADA Standards of Care in Diabetes. Diabetes Technology. 2026; Kumar N, et al. *J Diabetes Sci Technol.* 2026.

Planning a Hospital CGM Discharge Program



Potential Candidates

- New to insulin, especially basal + bolus
- A1c >9%
- Risk of hypoglycemia
- Hypoglycemia unawareness
- Steroid taper/continuation
- Enteral feedings
- Resolving infection
- Pregnancy
- Recurrent DKA

Practical Considerations

- **Obtain CGM** to place prior to discharge
- **CGM education** on placement, glucose goals, alerts, trend arrows, when to check glucose with BG meter
- **Connect CGM** to clinic account for follow up appointment
- **Schedule** follow up video or in person visit in 2 weeks to review data and adjust diabetes treatment plan post discharge

ADA Standards of Care in Diabetes. Diabetes Technology. 2026; Kumar N, et al. *J Diabetes Sci Technol.* 2026.



Let's Meet Eric

Case #3

Eric (56 years old)



Demographics

- Married, two children
- Works as an auto mechanic
- Hospitalized with abdominal pain
- Underwent laparoscopic appendectomy
- Now post-op day 2

Hospital Course

- Improving post-appendectomy, diet progressing
- Newly-diagnosed type 2 diabetes (T2D)
- Initiated insulin therapy in the hospital

Past Medical History

- Hypertension x 9 years; takes lisinopril 20 mg PO once daily
- Hyperlipidemia x 3 years; takes rosuvastatin 10 mg PO once daily

Labs

- Height = 171 cm; Weight = 98 kg, BMI = 33.5 kg/m²
- A1c = 9.2%
- Point-of-care glucose range = 69-337 mg/dL
- Multiple episodes of glucose <100 mg/dL
- Hemoglobin = 14.2 g/dL, hematocrit = 43%
- Serum creatinine = 1.1 mg/dL
- Estimated GFR = 63 mL/min

Diabetes Meds for Discharge

- Insulin glargine 20 units at 9 PM
- Metformin 500 mg PO once daily, to be increased by 500 mg weekly up to target of 1000 mg PO twice daily
- Sitagliptin 50 mg PO once daily
- Continue lisinopril and rosuvastatin

Inpatient Glucose Management

What Do the Guidelines Say?



- 2026 ADA Standards of Care in Diabetes – Sections:
 - 7. Diabetes Technology***
 - 16. Diabetes Care in the Hospital***

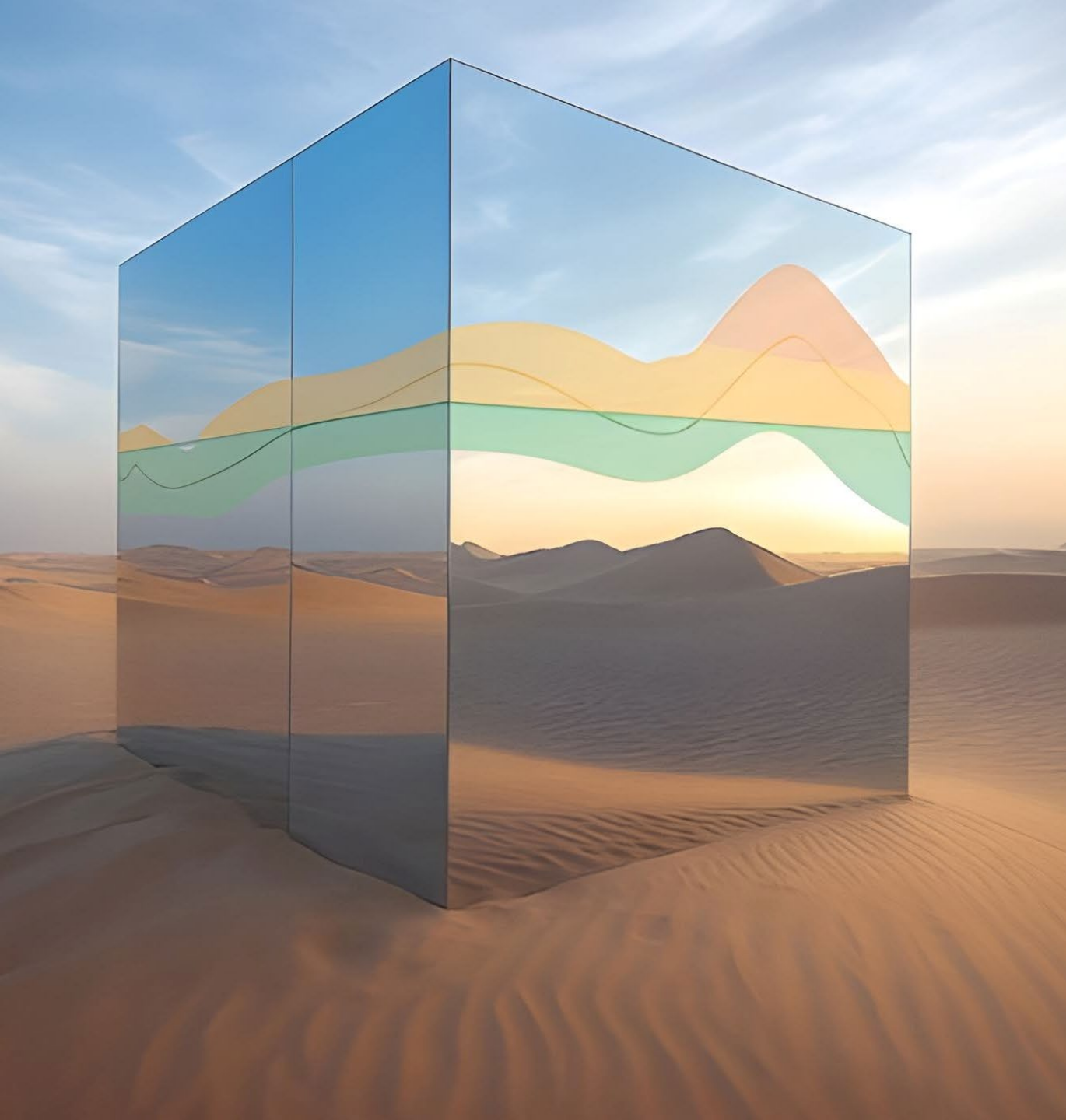


ADA Standards of Care in Diabetes. Diabetes Technology. 2026; ADA Standards of Care in Diabetes. Diabetes Care in the Hospital. 2026.

Summary



- eCQI Hospital Harm
 - Severe Hypoglycemia Measure: Hospitals should assess current state, identify root causes of hypoglycemia, and pilot interventions that may improve outcomes
- Current Status of CGM Use in Hospitals
 - CGM is currently restricted to use of personal CGMs to provide helpful information to the wearer and serve as an early warning to prevent hypo and hyperglycemia
- Inpatient Diabetes Tele-Consults
 - An opportunity to reach individuals who require complex diabetes care across campuses within health-systems, especially those with limited diabetes care experts
- CGM Discharge Program
 - An effective strategy to prevent emergency department visits and readmissions by monitoring glycemic management along with making just-in-time adjustments to the diabetes care plan



Activity Post-Test



Post-Test Question 1



Recent updates to diabetes quality measures now include which of the following as a clinician-level performance metric?

- A. Continuous glucose monitoring (CGM) utilization
- B. Insulin pump utilization only
- C. Continuous blood pressure monitoring
- D. Genetic testing for diabetes

Post-Test Question 2



Which of the following best describes how continuous glucose monitoring (CGM) supports achievement of diabetes quality metrics?

- A. Replaces the need for HbA1c testing in all patients
- B. Provides real-time glucose data to improve glycemic assessment and clinical decision-making
- C. Eliminates the need for routine complication screening
- D. Primarily improves blood pressure control independent of glycemia

Post-Test Question 3



Which combination of findings supports the conclusion that real-time CGM (RT-CGM) is cost-effective?

- A. A1c reduction of -0.3% and no QALY gain
- B. A1c reduction of -1.1%, QALY gain of 0.763
- C. Increased costs with no clinical benefit
- D. ICER exceeding \$150,000 per QALY

Post-Test Question 4



A 58-yo patient with T2D has an HbA1c of 9.2% despite oral therapy. They report inconsistent self-monitoring of blood glucose (SMBG) and difficulty identifying glucose patterns. What is the most appropriate next step to optimize diabetes monitoring?

- A. Continue current SMBG without changes
- B. Discontinue glucose monitoring
- C. Focus only on annual HbA1c monitoring
- D. Initiate RT-CGM to assess glucose patterns and guide therapy

Post-Test Question 5



How confident are you in your practical understanding of the benefits of CGM related to patient outcomes, cost-efficiency, and clinician performance?

- A. Extremely confident
- B. Very confident
- C. Moderately confident
- D. Slightly confident
- E. Not confident

Thank you for attending this session!

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