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## Leveraging CGM to Its Full Potential in People with T2D

### Announcer:

Welcome to CME on ReachMD. This activity is the second in a series titled, "In the Range: Real Talk on Diabetes Monitoring Best Practices." This is episode two, focusing on CGM and titled "Leveraging CGM to its Full Potential in People with T2D," is provided by Cornerstone Medical Education and AACME and is supported by an educational grant from Abbott Diabetes Care.

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### Dr. Anderson:

Continuous glucose monitoring, or CGM, has long been used for people with type 1 diabetes, but guidelines continue to evolve to increase recommended use in people with type 2 diabetes. Today, we'll dig into this topic before discussing practical applications. This is CME on ReachMD, and I'm Dr. John Anderson. I practice internal medicine and diabetes at the Frist Clinic in Nashville, Tennessee. And joining me today is Davida Kruger. Davida, if you'll introduce yourself.

### Davida Kruger:

Thank you, John. I'm Davida Kruger. I'm a certified nurse practitioner at Henry Ford Health in the Division of Endocrinology in Detroit, Michigan, and I'm really happy to be here today. Thank you.

### Dr. Anderson:

Well, Davida, thanks for being here today.

So why don't more patients have continuous glucose monitoring or CGM? Both the ADA, that's the American Diabetes Association and AACE, the American Association of Clinical Endocrinologists, recommend the use of CGM for many more patients with diabetes. We know, Davida, that patients get tremendous benefits from this. Lower A1Cs, increased time in range, less hypoglycemia. They modify their diet and exercise habits. They adhere to a personal eating plan. And we also just extend to the patients, right? It makes our office visit so much easier. I mean, sitting down with a patient in real time, looking at their highs and lows, looking at their daily patterns, making some clinical decisions. But what we know from the data is the vast number of patients, particularly with type 2 diabetes, are not getting access to the CGM. So Davida, why is that? And do you have some data that talks about the benefits of CGM?

### Davida Kruger:

Absolutely, John. You know, our world, both yours and mine, everybody gets CGM. We consider it, you know, a right, not a privilege. And I think the rest of the world is probably following suit as they're learning more about diabetes, managing it with CGM. And of course, as the research shows and as changing reimbursement and access and the demand from patients. But I really think that the patients are demanding CGM and soon the healthcare provider will follow. And I think you have outlined it beautifully is that how do you practice without the knowledge of CGM? So some of the benefits we've seen in A1C reduction, while A1C still matters, it's not the whole story. There's so many things that can interfere with A1C. And if you just give me A1C, what do I do? So if the A1C is 8%, do I make an adjustment in basal insulin? Do I add a GLP-1? What is it I do? There's nothing actionable about it. But then it's still familiar, so we're still going to order it. But CGM consistently demonstrate better outcomes, clinically meaningful A1C reductions in the DIAMOND trial,

the GOLD trial, the MOBILE trial, when we looked at type 2 diabetes versus finger stick and A1C, and superior was the CGM. And then when we look at time and range, which is the most actionable metric, and then the ADA now emphasizes time and range is a key glycemic outcome, which is now complementary to A1C, not the end-all, be-all A1C, time and range will reflect what I can do. So I can look at the patient's total time and range, and then if I have CGM, I can go back and look at where the blood sugars might be high or low that contribute to that time and range. So think of CGM time in range as being actionable data. That's the benefit to me as a healthcare provider. It's not just one point in time like a finger stick. And if you give me a percentage of an A1C over the last 30 to 90 days, I don't know what to adjust.

**Dr. Anderson:**

Right. And also, what's interesting is that with this evidence, Davida, the standard of care guidelines have changed. Why are we so excited about the new change for 2026 from the American Diabetes Association talking about the change in standard of care?

**Davida Kruger:**

Every December, the standards of care come out. We sort of wait, and then we do our happy dance if we got what we want. And I focus on CGM and other technology because as you know, that's what I do in life. So the big change, the big change for 2026 was saying it's no longer optional for type 1 diabetes. We are happy with that. Or for people insulin treated. That's standard of care. Anyone, anyone, type 1 or type 2, on insulin absolutely positively should be on CGM. But the other big change is we should start considering it and utilizing it for individuals who have type 2 diabetes who are on non-insulin therapies. And why is that important? Because we know if I give CGM to a person with diabetes just by seeing what's happening with their blood glucose data, when they eat, when they're active, when they're not active, they change what they're doing in life. They change behavior. And so we know even without changing medication in type 2 diabetes, those individuals would benefit. And then of course, there are medications that are not insulin that cause hypoglycemia. And we know that insulin causes hypoglycemia. So again, for all comers, but you know, from my perspective, everybody should be on CGM. And I think we're getting there because it helps both the person with diabetes and it certainly helps me be a much better practitioner.

**Dr. Anderson:**

We know it's interesting to video because I think a lot of times when we first were using CGM, we were talking only about insulin treated patients. We were talking about prevention and avoidance of hypoglycemia risk to be the end-all, be-all. And while that's clinically very, very important for a lot of patients, I think you really highlighted the fact that there is just much more broad utilization here that's possible for these patients.

So for those of you just tuning in, you're listening to CME on ReachMD. I'm Dr. John Anderson. And today I'm speaking with Davida Kruger about CGM use in people with type 2 diabetes. We spoke a bit earlier about the background on CGM, its benefits, and why it's so important. But now let's shift over to the data we get from CGM and how to use it.

So Davida, can you walk us through an ambulatory glucose profile or AGB and talk a little bit about what we can see there like time and range?

**Davida Kruger:**

Absolutely. So understand that this was developed by the international group that looked at all of the outputs of CGM and they said, okay, we're all going to go crazy if every company has their own output. Let's come up with one that unifies all of the readings, sort of like an EKG machine. And the AGB report is the one that we now use. It was developed by also the International Diabetes Center, by Richard Bergenstahl's group, and then adopted by the International. So that's all that we live by. We all live by the same. So time and range. Time and range for all of our patients or the majority of our patients, whether they have type 1 or type 2 diabetes, we want that greater than 70%. with less than 5% lows and less than 25% hyperglycemia. So if a patient is older, less life expectancy, you might adjust it. But I don't necessarily do that for older individuals because most of my older individuals are living a very vital life and they probably will have longevity and I want them to have really great blood sugars or data, great time and range. So I really think it depends on the individual. And of course, in pregnancy, we want as high as the time and range we can get. But for the majority of the patients, we're going to shoot for a time and range greater than 7%. So if I look at this data, it also gives me something called a GMI. What is a GMI? A GMI looks at the CGM data, and we're looking at 2 weeks worth of data. It takes that two weeks worth of data, and based on what the patient was doing, it gives you a sort of A1C. Now, it may not match the A1C. Why not? Because A1C is 30 to 90 days. So if the patient's diabetes was not very well controlled for the last 30 to 90 days, but I made changes, and in the last two weeks, the GMI and the time and range have improved, then I'm going to see that on the AGB report. And either I can make further changes or if we're doing great, we can keep with the program that the patient's doing moving forward. And then if I do another A1C, they may match. The next panel that we look at on the AGB report takes the last two weeks, smushes it all together, makes it look like 24 hours so that if you think about the old finger stick graphs when people used to hand you blood glucose diaries and they had a blood sugar here and a blood

sugar there and a blood sugar here, and you had to wrap your head around that, this takes every blood sugar or every glucose measurement that's been done by the CGM and puts it so that I can wrap my head around it. And if you're looking at this slide, you can see that sometime after the breakfast meal, this person is having a blood glucose rise, and I can then make adjustment just for that. The third panel is something that I get to see is daily. And it's daily for the last 14 days, and I can look at patterns. So if the blood glucose data for Friday nights or Sundays are similar, I can say, ooh, what's going on there? But this chart shows me the number of days the patient wore the sensor. We want 14 days. It tells me the percentage of time the patient wore. And for this patient, it was 70% for those of you looking at the slide. It gives me a GMI. It tells me the glucose variability, which you want that less than 30, so the patient's not on a roller coaster. And the beautiful thing about this is that I can capture it in my chart notes and next time I see the patient, I can look back and say, oh, look at the progress you made. But it helps me help the patient and also the patient has this data. I will say, however, if you are not looking at this data as a healthcare provider, I hope you'll learn how to look at it. It's pretty simple, but that's not a reason not to give a person with diabetes the ability to wear a CGM because they will make changes on their own. that improve the outcome as well.

**Dr. Anderson:**

Let's back up just a little bit, Davida. I want to talk with you about this topic that we all know a lot about, which is that topic of clinical inertia, right? Trying to get these patients down as quickly as they can, as we can, and keeping them down and eliminating that prolonged period of dysglycemia while we, for lack of a better word, you know, whether it's a provider, a clinician, or whether it's the patient who's dragging their feet. Sensors and CGM can play a big role in getting these patients down quickly. And it used to be you had to have a long duration of diabetes and you weren't doing well. Well, maybe now we'll try a sensor. Talk to me a little bit about from the very beginning, what's the benefit of getting that sensor on that patient?

**Davida Kruger:**

Well, first of all, we know if we apply the sensor the day we meet that person and their blood glucoses get under control, the CGM shows the data, the A1C, the time range, all of that fall into place, that individual actually over time will keep their data well controlled versus the person who maybe 10 years in gets a sensor, although they still do very well. So the data shows that the minute you meet that patient, they then get to see what's happening with their data. They change their behavior right away. They want to be engaged. And the inertia you've described, so here's what happens. A1C comes back eight. The person says to me, oh, I just had a rough time, I had a rough month, I'm going to do better, I'm going to do better. And that happens every three months. They come in and the same conversation occurs. Now, if I give that same individual a sensor, every day, they're looking at their data around the clock, and they can see that if they don't exercise or they're not physically active, or depending on their food choices, this is what happens to their data. And they may need to go from the therapy they're on to the next therapy, or they just need to change some behavior. So if I give that sensor from the get-go, I either get to use less medication, and or it's time to move that to the next level of medication, higher dosing, new type.

**Dr. Anderson:**

You know, Davida, those of us in primary care, we have 15 minutes with a patient, maybe 20, maybe 10 if they're doing well. But we also don't have the expertise, right? So we need to reach out to those team members that can help us with that individual patient, whether it's certified diabetes care and education specialists, pharmacists, I think you mentioned, dieticians, nurse practitioners, whoever can lend expertise, and not only expertise, but more time than I might have. We've found that invaluable, haven't we?

**Davida Kruger:**

Absolutely. I think the team approach is very important. And, I get more time than you do as a specialist, but I still don't have necessarily the time to teach. So all the resources out there, all the people out there, there's online, there's face to face, there's all kinds of resources that can help us educate the patient, not only how to start and use a sensor, but how to use the data as well. So I think we just need to gauge whatever folks we have available to us and make sure that patient is comfortable with using CGM and getting the maximum benefit from it.

**Dr. Anderson:**

Fantastic. So as we come to the end of our program, Davida, what do you think are the key takeaway for our clinicians to remember? We've covered several things.

**David Kruger:**

Well, you know, I don't think it's ever a good time to have diabetes, but this is about the best time in terms of not only CGM, but other technology and medications and everything we can offer people with diabetes. And as a clinician, you need to feel comfortable with CGM so that you prescribe it for all your patients that have diabetes. And you can decide how much bargain in or bargain out that you do with the data, but don't keep it from your patients. They will learn to use it and it will still give them a better outcome. So I really think the message moving forward is CGM is for people with type 1 and type 2 diabetes. Please prescribe it and offer it to your patients.

**Dr. Anderson:**

That is a great way to round out our discussion on these new CGM recommendations, Davida. I want to thank my guest, Davida Kruger, for helping us better understand use of CGM in people with type 2 diabetes. And Davida, once again, it was great speaking with you today.

**Davida Kruger:**

Always, John.

**Announcer:**

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