Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/cgm-real-t2d-world/50982/

Released: 05/13/2026
Valid until: 05/13/2027
Time needed to complete: 15 minutes

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

CGM in the Real T2D World

Announcer:
Welcome to CME on ReachMD. This activity is the fourth in the series titled, “In the Range: Real Talk on Diabetes Monitoring Best Practices.” This is episode four focusing on CGM, titled “CGM in the Real Type 2 Diabetes World.” It is provided by Cornerstone Medical Education and AACME and supported by an educational grant from Abbott Diabetes Care.

Before starting this activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Goldman:
Continuous glucose monitoring has long been used for patients with type 1 diabetes, but guidelines continue to evolve around use in patients with type 2 diabetes. Let's dig into new data supporting the use of CGM in people with type 2 diabetes and what it means for clinical practice. This is CME on ReachMD, and I'm Dr. Jennifer Goldman, and joining me to discuss new data for CGM use in people with type 2 diabetes is Dr. Francisco Javier Ampudia-Blasco. Dr. Ampudia-Blasco, thank you for being here today.

Dr. Ampudia-Blasco:
It was my pleasure to participate in this important discussion. Thank you.

Dr. Goldman:
To start us off, I'd like to share some background on why we're seeing less use of CGM in people with type 2 diabetes. Despite strong and growing evidence, CGM remains underutilized, particularly outside of endocrinology. And what we see in practice is that this is driven by multiple layers of barriers.

From a system standpoint, cost, insurance misalignment, and disparities in access continue to limit uptake, especially in underserved populations, and at the same time, prescribing CGM does not guarantee success because implementation challenges such as workflow constraints, limited provider training, and difficulty interpreting data can all impact use.

Even when patients start CGM, persistence becomes a major issue that could be due to device burden or skin reactions or usability challenges.

So really, the issue is not just who should receive CGM, but how we ensure it's implemented effectively while a system that supports access, education, and long-term use.

Dr. Ampudia-Blasco:
Yeah, for sure. So I think what you mentioned all things are happening, not only in the US, but also in Europe. So I think access to the CGM technology is not very easy for those people with type 2 diabetes, especially for those using basal insulin or even, for example, oral agents.

For many people who are also older people, you know, to understand how CGM is working is sometimes difficult. And also primary care physicians, on the other hand and also the teams in the primary care are not prepared enough to support and to give enough technical support for people with type 2 diabetes starting with CGM. And certainly, I think we need, obviously, much more evidence around the

outcome, how can we implement CGM in this population?

Dr. Goldman:
So, Dr. Ampudia-Blasco, can you walk us through what we've recently learned about the impact of CGM in older adults, particularly when it comes to time below range?

Dr. Ampudia-Blasco:
So Jennifer, regarding your question, we have a wonderful work from the Joslin Clinic in the US, in which particularly they evaluate, for example, how quickly older people, for example, can implement the use of CGM in their usual practice. And they develop an appropriate teaching program for these older people, and they show that even in the first month, they were able to see the benefits that will be maintained over longer time in terms also the time in range, and also without increasing time below range. They saw also a reduction in time above range. So that means that, in all, when you adapt the teaching program for older people, these people are able to implement, and also the benefits that you can see, it can very soon after the starting of the CGM use in this population.

Dr. Goldman:
Yeah, that's important. So the FReeDM2 trial CGM improved time in range, reduced time above range, while time below range remained low, unchanged, no increase in hypoglycemia or severe hypoglycemia events. So, reinforcing that CGM delivers both efficacy and safety, which is especially important in older adults.

Dr. Ampudia-Blasco:
Yeah, of course. So I think in the FReeDM study that you mentioned, obviously, there are involved people using basal insulin. And I think in this population, the benefits also come very often. And what is important in this important study from the UK that you mentioned is that in the first part of the study, in the 16 first weeks in which people were able to adjust the treatment by themselves, so they were also particularly improving in hemoglobin A1c, but also in different metrics of the CGM in the people without increasing the hypoglycemia risk.

What have recent study results shown us about the use of CGM in patients with type 2 diabetes on basal insulin?

Dr. Goldman:
This is where we're seeing some of the strongest and most practice-changing data in the FReeDM2 trial, CGM use in patients with type 2 diabetes on basal insulin, often in combination with GLP-1 receptor agonists or SGLT-2 inhibitors, led to a significant improvement in glycemic control. A1c decreased in the CGM group compared to a smaller reduction in the self-management blood glucose group. We also saw improvements in time in range and reductions in time above range without an increase in hypoglycemia, and more patients achieved clinically meaningful A1c targets.

So importantly, this is reinforced by real-world data where CGM use in patients on basal insulin was associated with similar improvements in time in range, reductions in hyperglycemia, along with improvements in glycemic variability, even without intensifying insulin therapy. So this really challenges the idea that CGM is only useful for patients on intensive insulin. Even in basal insulin populations, it provides clear and meaningful benefit. And importantly, this is not just about glucose lowering; CGM enables more informed treatment decisions and supports self-titration in real time.

Yeah, and that highlights that CGM supports more informed treatment decisions, enables safer and more effective self-management.

For those of you tuning in, you're listening to CME on ReachMD. I'm Dr. Jennifer Goldman, and today I'm speaking with Dr. Francisco Javier Ampudia-Blasco about CGM use in patients with type 2 diabetes.

Dr. Ampudia-Blasco, let's continue to dive into new data and what it means for practice. What have we learned recently about the use of CGM for lifestyle changes?

Dr. Ampudia-Blasco:
So this is a particularly important question because we are not focusing only on the metrics. But what we learned, for example, from the FReeDM study from the UK is that even, for example, when you use accelerometers to evaluate, for example, physical activity of people involved in this particular study, even in the 16 first weeks in which people were using CGM without any particular support driven for the doctors, they were able, for example, to increase total daily activity. And I think this is an important guess that means that CGM, also the information that basically comes from the CGM, they help them, for example, to adapt the habits, also activities, obviously, that approximately by 12 minutes per day. But I think that makes sense, and this difference was significant.

Dr. Goldman:
Yeah, even short-term CGM use leads to meaningful behavioral changes. And there was over 90% of participants gaining new insights

into how their habits affect glucose, and what 75% making changes in diet and portion size, physical activity, in many of which was sustained over time and closely linked to how actively patients engage with that new CGM data.

Dr. Ampudia-Blasco:
So I think, we're speaking not only about CGM in terms of improving hemoglobin A1c or some metrics related to glycemia, this is also an important tool to help people to change behavior and to improve physical activity and to improve also the practices. So all in all, I think this is important guest also for the audience.

Now, Dr. Goldman, how can CGM impact non-glycemic parameters like quality of life, hypoglycemia confidence, and patient empowerment? And how does the diabetes care team play a role here?

Dr. Goldman:
What is important is that CGM is not just improving glycemic metrics, it's meaningfully improving how patients experience their diabetes day to day. So in randomized data, CGM use was associated with significant improvements in treatment satisfaction, quality of life, and dietary habits, along with increased confidence in managing hypoglycemia. Patients also reported a better understanding of their condition and a greater ability to adjust their medications in real time. So this reflects a shift towards more informed and engaged self-management.

And we also see this reinforced in real-world data, where consistent CGM use is associated with improved time in range and a strong sense of patient empowerment. So patients describe using CGM to guide decisions around food, activity, medications, and those who use it consistently tend to have better outcomes and greater confidence in managing their diabetes.

But an important piece of this is that CGM does not work in isolation. Diabetes care team plays a critical role in helping patients interpret the data, translate it into actionable changes, and sustain engagement over time. And that includes not just clinicians, but nurses and dietitians and diabetes educators, and pharmacists, and behavioral health support, all of whom help reinforce education, address barriers, support long-term care.

So ultimately, CGM enhances not only clinical outcomes, but also patient confidence, autonomy, overall quality of life, especially when it's supported by a strong interprofessional care team.

Dr. Ampudia-Blasco:
Yeah, you are completely right what you mentioned. And I think, as there are also from ATTD in Barcelona this year, so several abstracts that support what you did. And I think this is an important guest for the audience.

Dr. Goldman:
Yeah, consistent CGM supports patient empowerment, real-time decisions that they can make.

Alright. Dr. Ampudia-Blasco, we're almost out of time, but before we close, could you share how recent data on CGM and impaired awareness of hypoglycemia in type 1 diabetes might apply to patients with type 2 diabetes?

Dr. Ampudia-Blasco:
Yeah, thank you for this question, which is an important one. Hypoglycemia unawareness is something that we know in people using intensified insulin therapy, particularly in people with type 1, but not only in people with type 1 diabetes, also in people with type 2 diabetes.

From this Congress, we know an important data also from Denmark. So it was a very nice study performed in people with type 2 diabetes, in which they, using several tests to evaluate hypoglycemia awareness, they found that approximately 10% they have impaired awareness of hypoglycemia.

And for these people, CGM was able to demonstrate that in higher proportion of patients with impaired awareness, they have asymptomatic hypoglycemia, but with alarms. And on the other hand, for example, for people having also symptomatic hypoglycemia, also in people with impaired awareness, they were not information.

So I think that CGM can be used as a technical awareness of hypoglycemia. It can be very useful, but not only in people with type 1 diabetes. I think that for those people with type 2 diabetes using insulin, particularly multiple daily injections, also CGM can help these people to have increased awareness about hypoglycemia and to prevent also and treat adequately these episodes of hypoglycemia. Thank you for the question.

Dr. Goldman:
Yeah, that's an excellent point. So this study, although was conducted in type 1 diabetes, the broader concept absolutely applies to type 2 diabetes as well, and especially older adults and patients with long-standing diabetes or those using insulin, so they may also have

that reduced hypoglycemia awareness you were just talking about. So thank you.

Ultimately, the data consistently show that CGM improves outcomes across glycemic control, behavior, and patient experience. CGM is no longer just about glucose monitoring; it's about empowering patients, improving safety, and transforming how we deliver diabetes care. And that's a great way to round out our discussion on new data supporting the use of CGM in patients with type 2 diabetes.

I want to thank my guest, Dr. Ampudia-Blasco. And Dr. Ampudia-Blasco, it was so great speaking with you today.

Dr. Ampudia-Blasco:
Thank you, Jennifer. So it was really a pleasure to be here and to discuss with you this important topic. And I think that the important guest for this Congress will help many people using more CGM in people with type 2 diabetes without intensified insulin therapy. Thank you so much.

Announcer:
This activity was provided by Cornerstone Medical Education and AACME. To receive your free CME credit, be sure to complete the post-test and evaluation at CME on ReachMD.com. Thanks for listening.