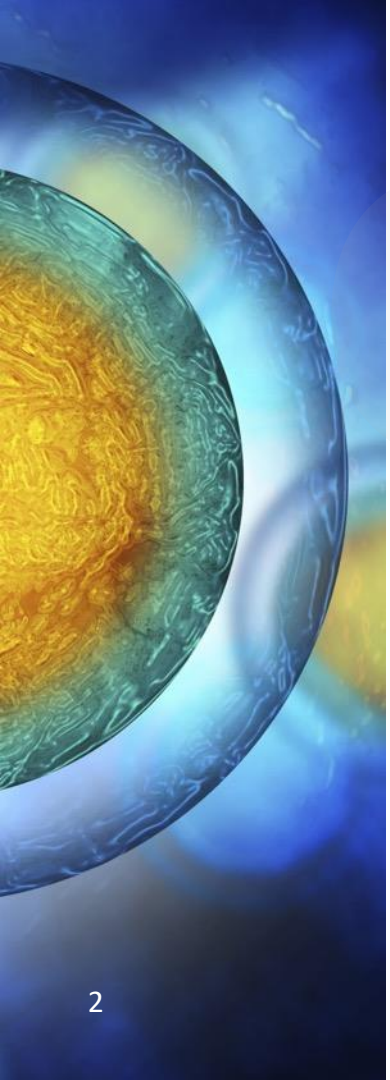
Diabetes State of the Art

High Impact Evidence-Based Pearls for Management

DATE: February 9th 2026 PRESENTED BY: Leah Baruch, MD and Caroline Barrett, MD



Goals for today

- Review available pharmacotherapy and monitoring options for Type 2 Diabetes
- Discuss evidence basis for newer therapies with a lens on:
  - Mortality
  - Cardiovascular risk
  - Chronic Kidney Disease
  - Quality of life

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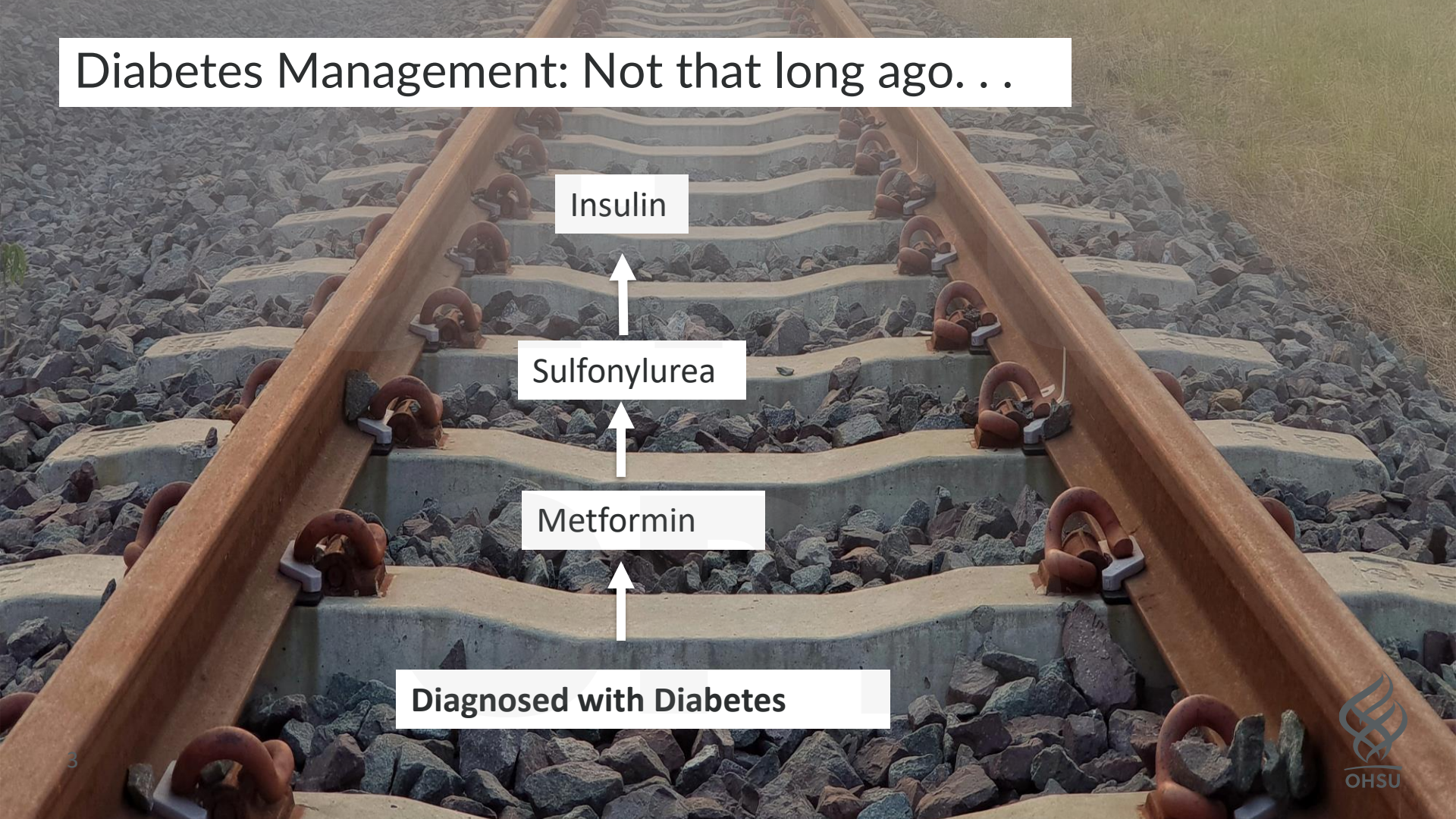
Diabetes Management: Not that long ago. . .



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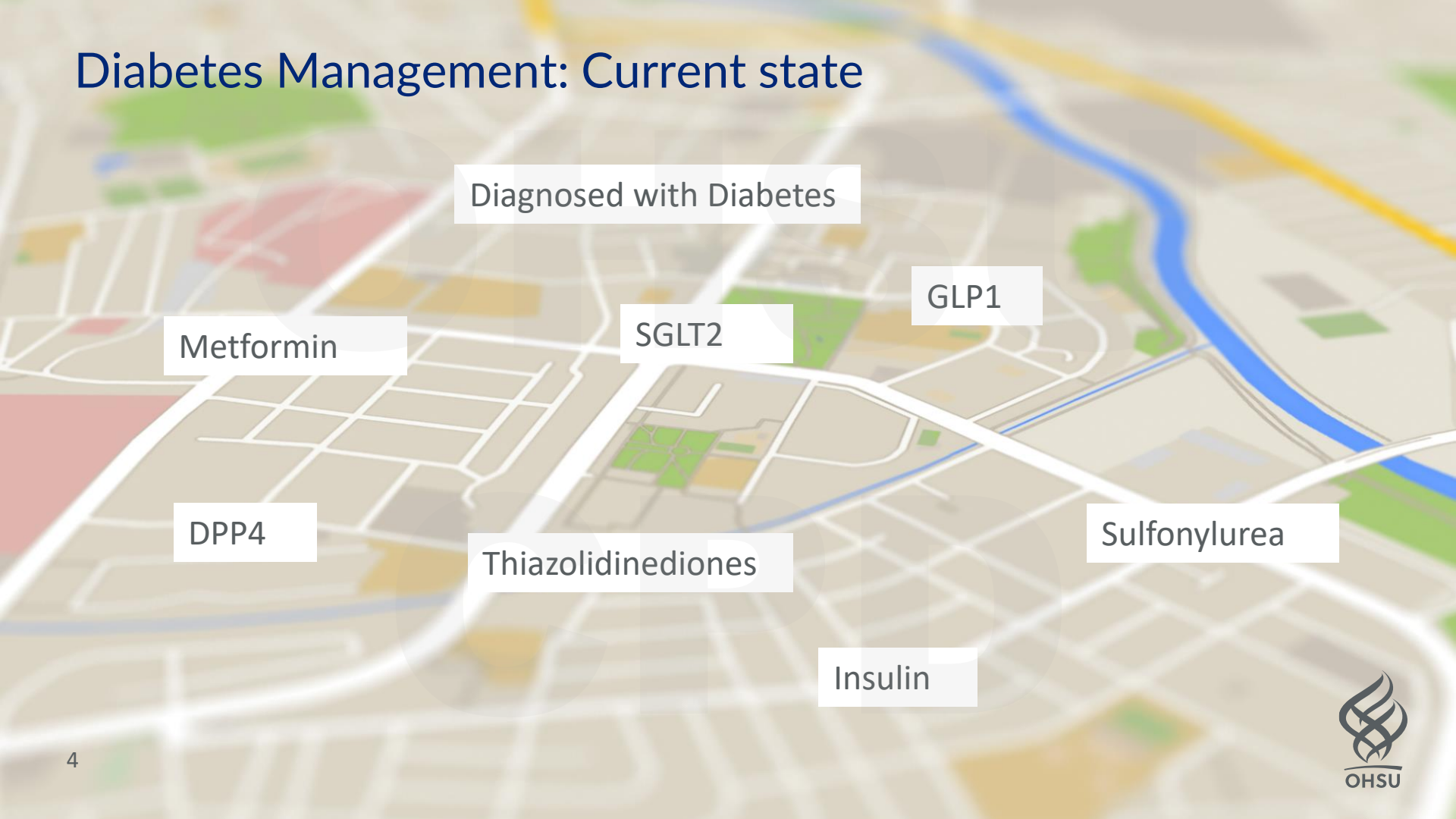
Diabetes Management: Current state



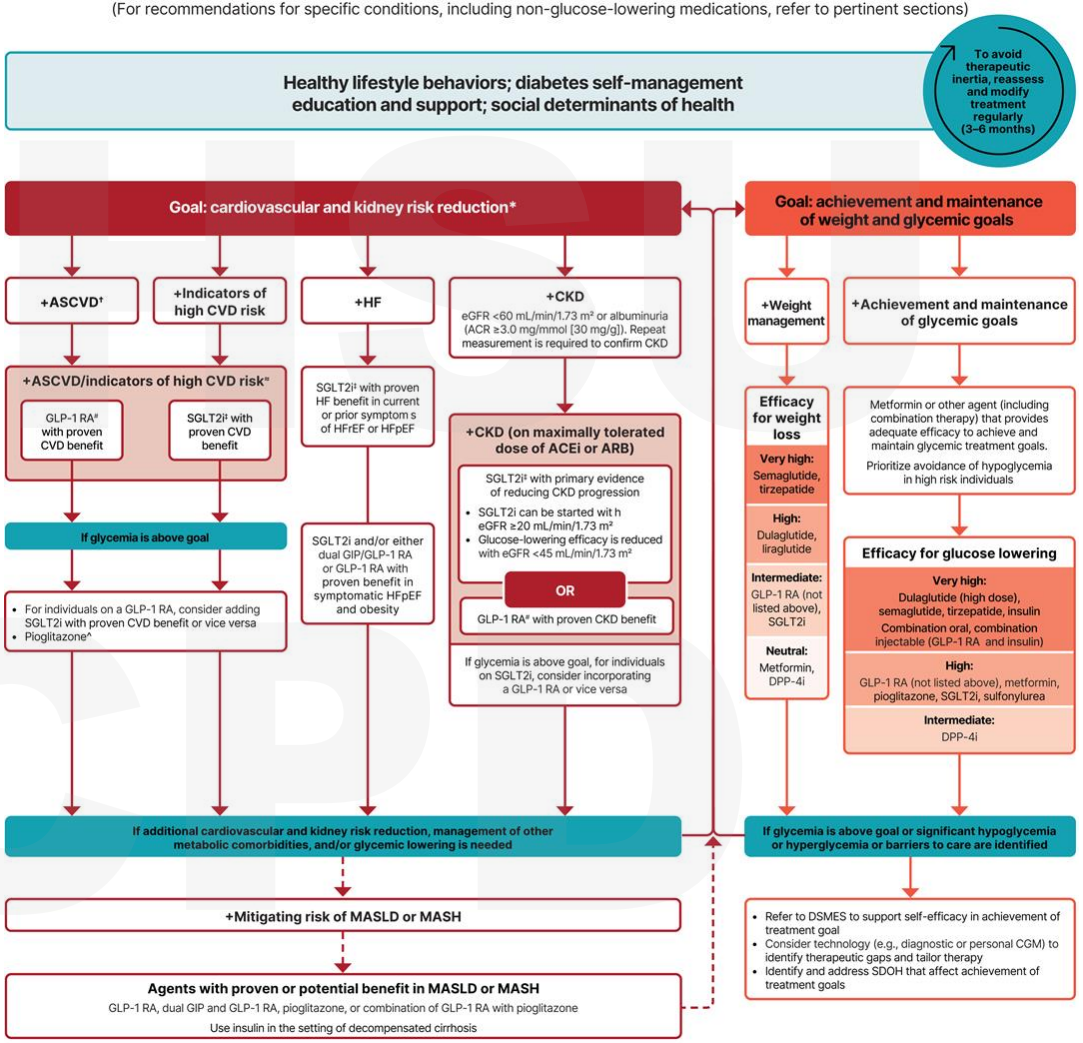
American Diabetes Association®

From: **9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026**

Diabetes Care. 2025;49(Supplement_1): S183-S215. doi:10.2337/dc26-S009

Use of glucose-lowering medications in the management of type 2 diabetes

(For recommendations for specific conditions, including non-glucose-lowering medications, refer to pertinent sections)



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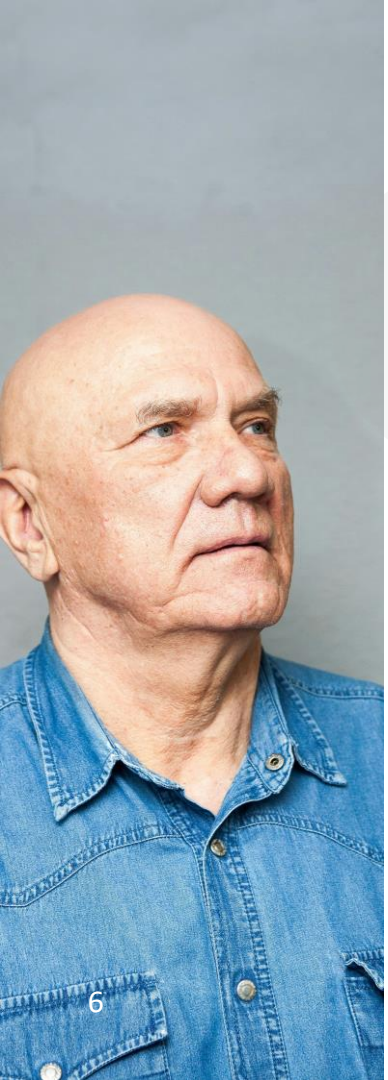

Your Patient: "Frank"

- 60 y/o male with 20 year history of Type 2 Diabetes, coming to establish care with you
  - History CKD 3b, last urine microalbumin 150 mg/dL
  - BMI 32, recent dx of MASLD
  - A1c today is 7.6%
    - Reports hypoglycemia once a week
  - Dad had an MI at age 61
- "I need refills of my metformin and glipizide."
  - On metformin 2000mg and glipizide 5mg once daily x 10 years

What next?

a) Refill current meds unchanged
b) Increase the glipizide dose
c) Start semaglutide
d) Start tirzepatide
e) Start empagliflozin
f) Start sitagliptin
g) Start pioglitazone

60 y/o male with 10 year history of Type 2 Diabetes

- History CKD 3b
- BMI 32
- MASLD
- A1c 7.6%
- Hypoglycemia
- Family history MI
- On metformin 2000mg and glipizide 5mg once daily x 10 years

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What are the goals in diabetes treatment?

- **Reduce mortality**
- **Prevent complications related to diabetes**
  - CKD, MI, Stroke, CHF, DM retinopathy, peripheral neuropathy
- **Maintain/maximize quality of life**
  - Tolerability of treatment
  - Achievement of secondary goals (ie weight loss)
- **Avoid adverse events**
  - Severe hypoglycemia, treatment-related side effects
- **Normalize blood sugar**

One way we can classify medication

DPP4 (Sitagliptin) Sulfonylurea (Glipizide) Insulin (Glargine, NPH)	"Just for Glucose"
Metformin TZD (pioglitazone)	"Glucose plus one"
SGLT2 inhibitor GLP1 agonist GLP1/GIP agonist	"Swiss Army Knife"

American Diabetes Association Professional Practice Committee for Diabetes*; 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026. *Diabetes Care* 1 January 2026; 49 (Supplement_1): S183–S215.

Drake T, Landsteiner A, Langsetmo L, et al. Newer pharmacologic treatments in adults with type 2 diabetes: a systematic review and network meta-analysis for the American College of Physicians. Ann Intern Med *2024 May;177(5):618-632.*

Tools in the toolbox: Just for Glucose

Drug Class	Examples	Specific Indications	Adverse effects
Short-acting insulin **Long-acting insulin**	Lispro (Humalog) Aspart (Novolog) Humulin (70/30, Regular, N) NPH Glargine Toujeo (U-300)	Glucose lowering	Hypoglycemia Weight gain
Sulfonylurea	Glipizide Glyburide	Glucose lowering	Hypoglycemia Weight gain
DPP4 inhibitor	Sitagliptin (Januvia) Saxagliptin (Onglyza) Linagliptin (Tradjenta)	Glucose lowering	Pancreatitis

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Tools in the toolbox: Glucose plus One

Drug Class	Examples	Specific Indications	Adverse effects
Metformin	Metformin	Glucose lowering CV Risk reduction	GI side effects B12 deficiency
TZDs	Pioglitazone	Glucose lowering MASH	Fluid retention CHF exacerbation Bladder cancer

American Diabetes Association Professional Practice Committee for Diabetes*; 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026. *Diabetes Care* 1 January 2026; 49 (Supplement_1): S183–S215.

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Tools in the Toolbox: Swiss Army Knives

Drug Class	Examples	Specific Indications	Adverse effects
SGLT2 inhibitor	Empagliflozin (Jardiance) Dapagliflozin (Farxiga) Canagliflozin (Invokana)	ASCVD risk reduction CKD MASH Weight loss Glucose lowering	Genitourinary infection Fournier's gangrene **DKA** Possible incr. risk amputation
GLP-1 Receptor Agonist	Semaglutide (Ozempic/Rybelsus) Dulaglutide (Trulicity) Liraglutide (Victoza)	ASCVD risk reduction CKD MASH Weight loss Glucose lowering	GI side effects Weight loss Pancreatitis Non-arteritic ischemic optic neuritis Gastroparesis
GLP-1/GIP RA	Tirzepatide (Mounjaro)	ASCVD risk reduction CKD (maybe) MASH Weight loss Glucose lowering OSA	Same as GLP-1 RA

American Diabetes Association Professional Practice Committee for Diabetes*; 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026. *Diabetes Care* 1 January 2026; 49 (Supplement_1): S183–S215.

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Drake T, Landsteiner A, Langsetmo L, et al. ***Newer pharmacologic treatments in adults with type 2 diabetes: a systematic review and network meta-analysis for the American College of Physicians.*** Ann Intern Med *2024 May;177(5):618-632.*

Trials were eligible if they enrolled **adult participants aged 18 years or older** with T2DM; evaluated **SGLT2 inhibitors, GLP1 agonists, DPP4 inhibitors, or long-acting insulins**; had treatment **duration of at least 52 weeks**; enrolled at least **500 participants**; and reported any outcome of interest.
For **medications approved after protocol development (for example, GLP1/GIP agonists)**, RCTs lasting 6 months or longer were eligible for inclusion.

- Outcomes compared to usual care
- Most study participants were **also taking metformin and ACEi or ARB**

Comparing the evidence

Drug class	All-Cause Mortality	Major Adverse Cardiovascular Event	CHF Hospitalization	CKD Progression	Adverse events	Severe Hypoglycemia	Weight Loss
SGLT2 inhibitor	**+ (RR 0.86)**	**+ (RR 0.90)**	**++ (RR 0.64)**	**++ (RR 0.66)**	**+ (RR 0.98)**	**+ (RR 0.85)**	+ (mean loss of 2.48 kg)
GLP-1 agonist	**+ (RR 0.88)**	**+ (RR 0.91)**		++ *(RR 0.76)***			+ (mean loss of 2.22 kg)
GLP1-GIP agonist							++ (mean loss of 8.47 kg)

- ***Data from newer study not included in meta-analysis*

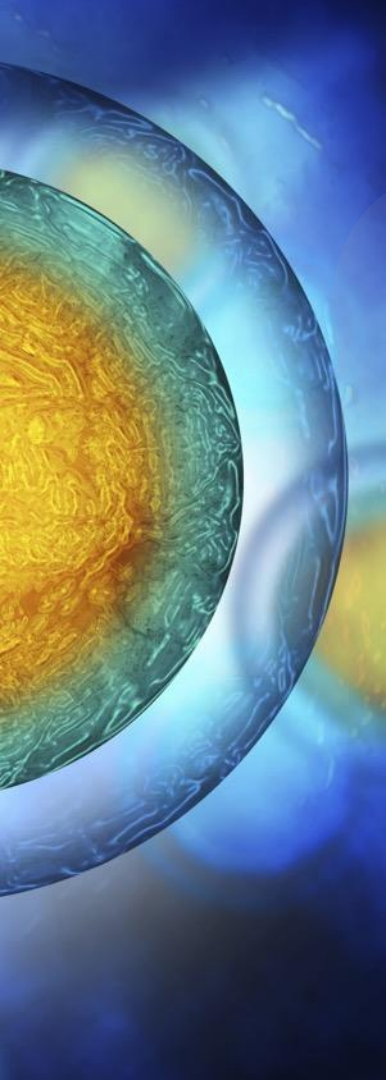
Drake T, Landsteiner A, Langsetmo L, et al. Newer pharmacologic treatments in adults with type 2 diabetes: a systematic review and network meta-analysis for the American College of Physicians. Ann Intern Med 2024 May;177(5):618-632.

***Perkovic, Vlado, et al. "Effects of semaglutide on chronic kidney disease in patients with type 2 diabetes." New England Journal of Medicine 391.2 (2024): 109-121.*

Comparing the benefits: Head to Head

Drug class	All-Cause Mortality	Major Adverse Cardiovascular Event	CHF Hospitalization	CKD Progression	Adverse events	Severe Hypoglycemia
SGLT2 inhibitor **Vs** **GLP-1 agonist**	No difference	No difference	**Favors SGLT2 inhibitor (RR 0.69)**	Insufficient evidence	No difference	No difference
SGLT2 inhibitor **Vs** **GLP1-GIP agonist**	Insufficient evidence	Insufficient evidence	Insufficient evidence	Insufficient evidence	No difference	No difference
GLP1 agonist **Vs** **GLP1 – GIP agonist**	No difference	No difference	Insufficient evidence	Insufficient evidence	**Favors GLP-1 agonist (RR 0.57)**	No difference

Drake T, Landsteiner A, Langsetmo L, et al. Newer pharmacologic treatments in adults with type 2 diabetes: a systematic review and network meta-analysis for the American College of Physicians. Ann Intern Med *2024 May;177(5):618-632.*



Bottom Lines

- **Avoid treatment inertia!**
  - Change from 'glucose-only' agents to newer pharmacotherapies when feasible
  - Assess patient goals beyond glucose control
- **Consider addition of SGLT2 in appropriate patients regardless of A1c**
  - Indicated for CKD, CHF, CVD risk
  - Glucose-lowering effects go down at lower GFR, but other benefits remain
- **Consider GLP1 RA in appropriate patients regardless of A1c**
  - Indicated for CKD, CHF, CVD risk
  - Oral and subcutaneous available
- **Don't forget about MASH**
  - GLP1 RA, SGLT2i, Pioglitazone have probable or proven benefit
- **Oregon Health Plan will cover these (if already on metformin):**
  - SGLT2i: Empagliflozin, Dapagliflozin
  - GLP1 RA: Dulaglutide, Liraglutide

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What next?

a) Refill current meds unchanged
b) Increase glipizide dose
c) Start semaglutide
d) Start tirzepatide
e) Start empagliflozin
f) Start sitagliptin
g) Start pioglitazone
h) Start empaglifozin AND semaglutide

What if:

- Frank's goal is to avoid CKD progression?
- His goal is weight loss to help his knees and sleep apnea?
- Frank's A1c were 6.4%?
- Frank had biopsy-proven MASH?

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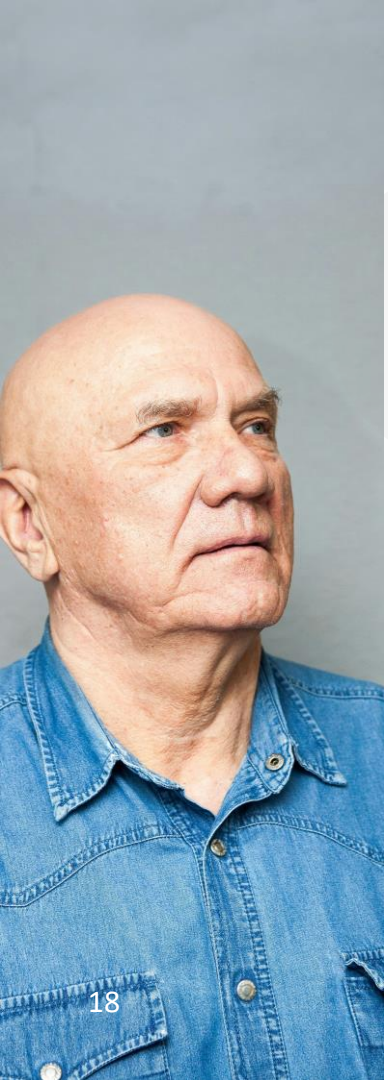
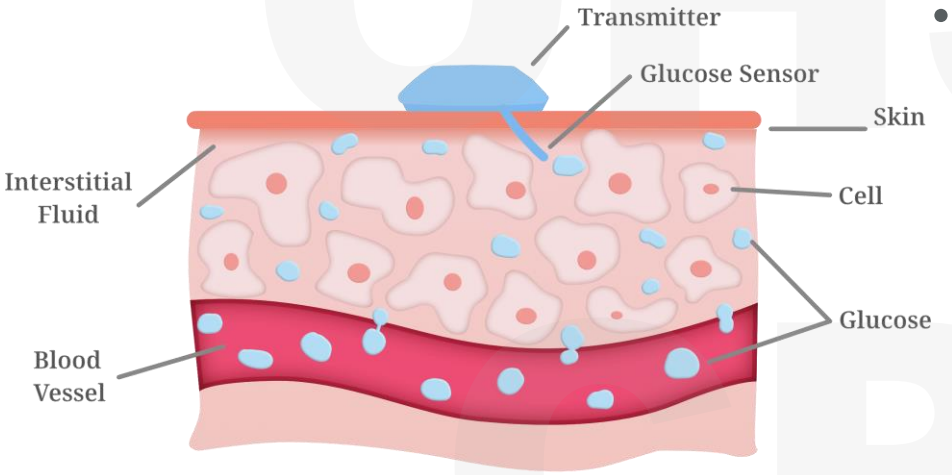


Back to Frank:

- Your patient starts empagliflozin as his primary goal is to keep his kidneys healthy and avoid dialysis.
- The next time you see him, he asks the following question:
  - –My wife says I should get one of those glucose monitors that goes on my arm. What do you think?

How it works



- Measures glucose in interstitial fluid through filament like sensor inserted into skin

Patients to consider

- Any patients on insulin
- Non-insulin medication use but not at A1c target
- Frequent, severe hypoglycemia or hypoglycemia unawareness
- Patients needing motivation and/or lifestyle pattern recognition

Real Time vs Intermittent Scanning

Pros	Cons
Offers alerts	Requires set up and programming
Transmits data continuously	Alarm fatigue
Shares data	Can be expensive
Can calibrate with fingersticks	False lows and highs

Pros	Cons
Easy to use, discreet	No alerts
More affordable	Requires intent
Shares data	No option to calibrate
Eliminates fingersticks	False lows and highs

-American Diabetes Association. Choosing a CGM. ADA. diabetes.org. https://diabetes.org/about-diabetes/devices-technology/choosing-cgm
-Heinemann L. Interferences With CGM Systems: Practical Relevance?. J Diabetes Sci Technol. 2022;16(2):271-274. doi:10.1177/19322968211065065
-Setford SJ. The Impact of Interfering Substances on Continuous Glucose Monitors: Part 2: Marketed CGM Designs, Labeled Interfering Substances, and Design Mitigations. *J Diabetes Sci Technol*. Published online October 16, 2025. doi:10.1177/19322968251377008

The Evidence: Efficacy and safety of continuous glucose monitoring and intermittently scanned continuous glucose monitoring in patients with type 2 diabetes: a systematic review and meta-analysis of interventional evidence. Seidu Et al. Diabetes Care 2024

Outcome	Real-Time	Intermittent Scan
A1c reduction	**Yes** at longest time point measured but not at time points of 12, 24 & 30 weeks. **-0.19% Mean difference**	**Yes** at longest time point measured and at 12 & 30 weeks. **-0.31% Mean difference**
Time in Range (70-180)	No difference	**Increased % Time in Range**
Time Below Range	No difference in time <54 or time < 70	No difference
Time Above range	**Increased time > 140, reduced time > 180**, no difference > 250	No difference > 180, **reduced time > 250**
Glucose Variability (coefficient of variation)	No difference	No difference
Weight/BMI/ waist circumference	No difference	No difference
Blood pressure	No difference	Single study increase in systolic BP, no change diastolic

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The Evidence Continued

Outcome	Real-Time	Intermittent Scan
Lipids	No change	No change
Medication Changes	**Reduction in glycemic medications**	Not reported
Adverse events (insertion site symptoms/infection, hypoglycemia, headache, GI sx)	**Increased** with no difference in hypoglycemia, severe hypoglycemia and DKA	**Increased** with no difference in hypoglycemia, severe hypoglycemia and DKA
Psychological measures (ie diabetes distress score, quality of life score, well being score, depression score)	No difference. However **CGM reduced satisfaction scores** vs usual care	Increased satisfaction scores with no differences in diabetes distress, well-being or quality of life scores

Seidu S, Kunutsor SK, Ajjan RA, Choudhary P. Efficacy and Safety of Continuous Glucose Monitoring and Intermittently Scanned Continuous Glucose Monitoring in Patients With Type 2 Diabetes: A Systematic Review and Meta-analysis of Interventional Evidence. *Diabetes Care*. 2024;47(1):169-179. doi:10.2337/dc23-1520

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Interpreting CGMs: Ambulatory Glucose Profile

GLUCOSE STATISTICS AND TARGETS

	14 Days
% Time CGM is Active	100%

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	152 mg/dL
Glucose Management Indicator (GMI)	6.9%
Glucose Variability	29.7%

Defined as percent coefficient of variation (%CV); target ≤36%

TIME IN RANGES

Very High	>250 mg/dL	4% (58min)
High	181 - 250 mg/dL	19% (4h 34min)
Target Range	70 - 180 mg/dL	77% (18h 28min)
Low	54 - 69 mg/dL	0% (0min)
Very Low	<54 mg/dL	0% (0min)

Aleppo G. Clinical Application of Time in Range and Other Metrics. *Diabetes Spectr*. 2021;34(2):109-118. doi:10.2337/ds20-0093

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Time in Range

- Time in Range (glucose 70-180): Goal of 70% (16 hours, 48 minutes), correlates to A1c of 6.7-7%
  - For older/high risk individuals, goal of 50%

- Time below range
  - Level 1: 54-69, goal of < 4% (< 1 hour)
    - Older/high risk < 1% (<15 min)
  - Level 2: < 54, goal of < 1% (<15 min)

- Time above range
  - Level 1: > 180, goal of < 25 % (< 6 hours)
    - Older/high risk <50%
  - Level 2: >250, goal < 5% (1 hour)
    - Older/high risk, < 10%

Aleppo G. Clinical Application of Time in Range and Other Metrics. *Diabetes Spectr*. 2021;34(2):109-118. doi:10.2337/ds20-0093

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Using CGMs: Glycemic variability

- Coefficient of Variation (Standard deviation ÷ mean) expresses degree of glycemic variability
  - Above goal of ≤36 percent has increased risk of hypoglycemia

Aleppo G. Clinical Application of Time in Range and Other Metrics. *Diabetes Spectr*. 2021;34(2):109-118. doi:10.2337/ds20-0093

Ambulatory Glucose Profile

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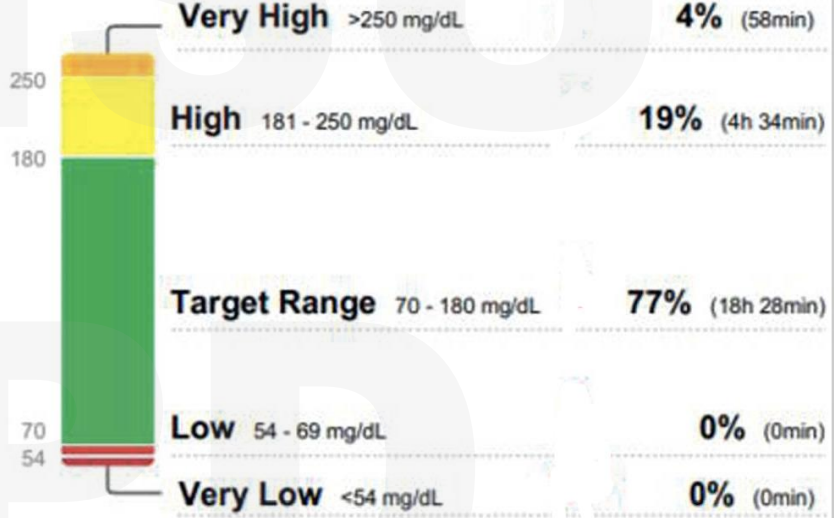

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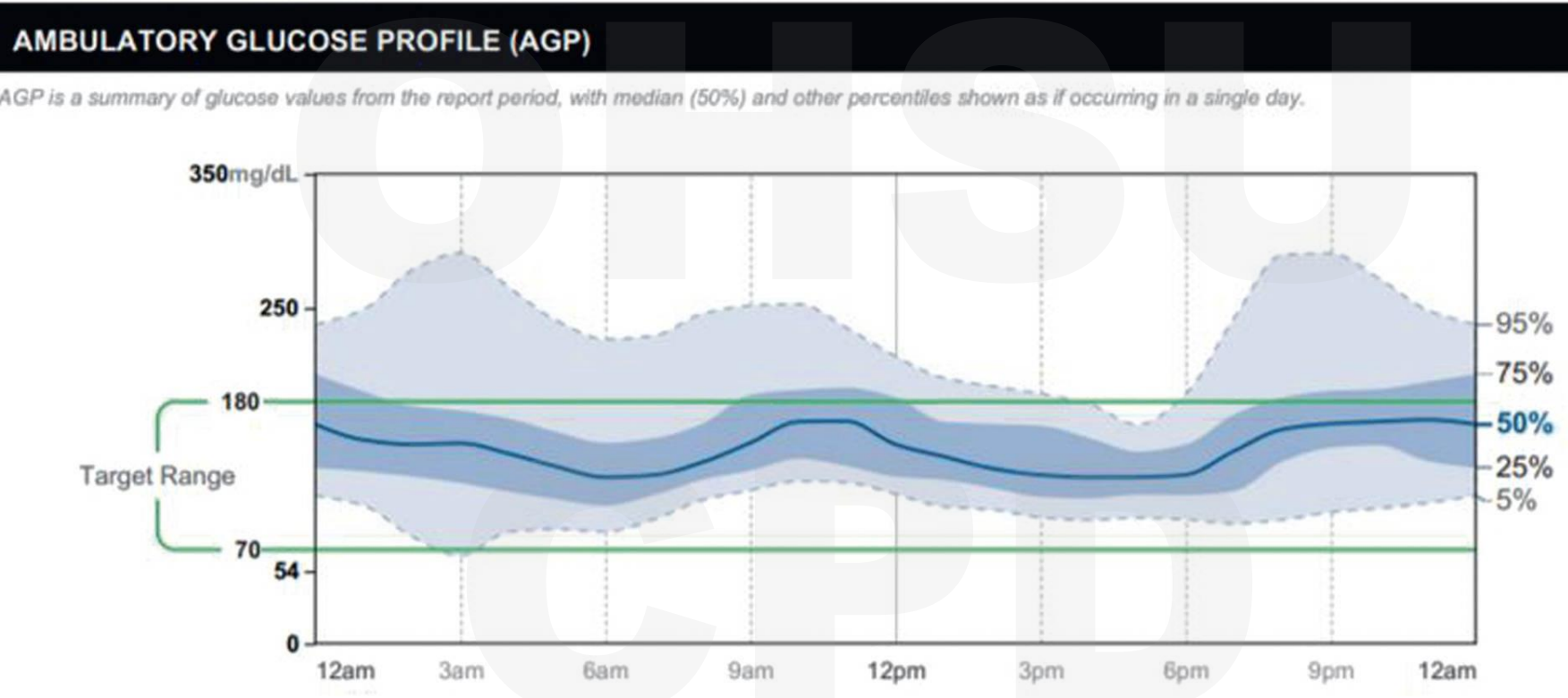
Ambulatory Glucose Profile



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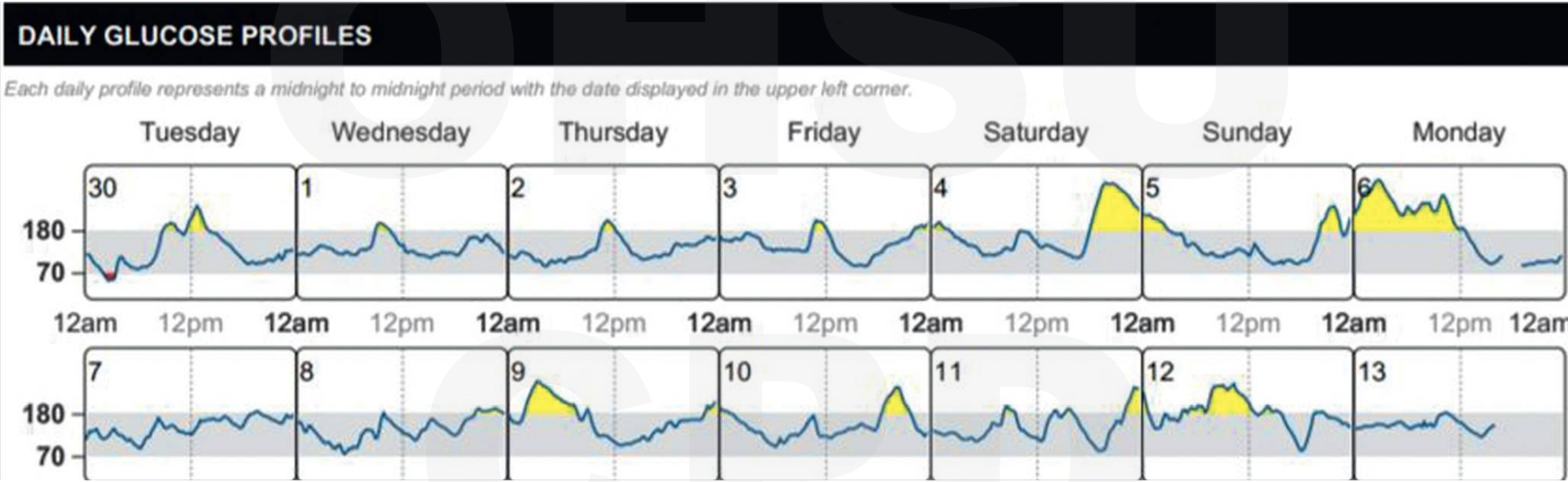
Ambulatory Glucose Profile



Aleppo G. Clinical Application of Time in Range and Other Metrics. *Diabetes Spectr*. 2021;34(2):109-118. doi:10.2337/ds20-0093

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It's been 3 months. What next?

a) Refill current meds unchanged
b) Increase the empagliflozin dose
c) Start semaglutide or tirzepatide depending on insurance
d) Have a conversation about mid-day meals and Saturday night
e) A & D

60 y/o male with 10-year history of Type 2 Diabetes. On metformin, glipizide & empagliflozin.

- GMI 6.9%
- Time in range 77%
- Time above range 23%
- Time below range < 1%
- Average glucose 152
- Glucose variability 29.7%

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Utility of CGMs:

- Can help identify trouble spots and patterns
  - Unidentified hypoglycemia
  - Unidentified postprandial spikes
  - Unknown of highs/lows (weekdays vs weekends, specific meals that trigger highs or lows, binge drinking on weekends)

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Device Details

Device Name	Frequency of Readings	Approved Ages	Placement Location	Sensor Life	Calibration	Warm up Time	Potential Interfering Substances	Alerts
Abbott FreeStyle Libre 2	Every 1 minute	≥4 years	Back of Upper arm	14 days	No	1 hour	➢ 500 mg Vitamin C per day	Yes
Abbott FreeStyle Libre 2 Plus	Every 1 minute	≥2 years	Back of Upper arm	15 days	No	1 hour	➢ 1000 mg Vitamin C per day	Yes
Abbott FreeStyle Libre 14 Day	Every 1 minute	≥18 years	Back of Upper arm	14 days	No	1 hour	Vitamin C, Salicylic acid	No; trend arrows
Abbott FreeStyle Libre 3	Every 1 minute	≥4 years	Back of Upper Arm	14 days	No	1 hour	➢ 500 mg Vitamin C per day	Yes

CGM Device Comparison. American Association of Clinical Endocrinology. https://pro.aace.com/cgm/toolkit/cgm-device-comparison

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Device Details

Device Name	Frequency of Readings	Approved Ages	Placement Location	Sensor Life	Calibration	Warm up Time	Potential Interfering Substances	Alerts
Abbott FreeStyle Libre 3 Plus*	Every 1 minute	≥2 years	Back of Upper Arm	15 days	No	1 hour	➢ 1000 mg Vitamin C Per day	Yes
Dexcom G6	Every 5 minutes	≥2 years	Abdomen or upper buttocks for patients 2-17 years	10 days	No	2 hour	Hydroxyurea & APAP (> 1 g every 6 hours in adults)	Yes
Dexcom G7*	Every 5 minutes	≥2 years	Back of Upper arm or upper buttocks for patients 2-6 years	10 days plus a 12-hour grace period	Factory calibrated. Calibrate option also available	30 min	Hydroxyurea & APAP (>1 g every 6 hours in adults)	Yes

CGM Device Comparison. American Association of Clinical Endocrinology. https://pro.aace.com/cgm/toolkit/cgm-device-comparison

***Integrate with Insulin pumps**

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Device Details

Device Name	Frequency of Readings	Approved Ages	Placement Location	Sensor Life	Calibration	Warm up Time	Potential Interfering Substances	Alerts
Stelo by Dexcom	Every 15 minutes	≥18 years, not on insulin and not at risk of hypo-glycemia. **No Rx!**	Back of Upper Arm	15 days plus 12-hour grace period	No	30 min	APAP > 1 g every 6 hours; hydroxyurea	No; visual notifications and glucose insights provided
Medtronic Guardian Connect	Every 5 minutes	14-75 years	Abdomen or back of upper arm	7 days	Yes (at start & then at least every 12 hours)	2 hour	APAP or paracetamol	Yes
Eversense 365 CGM System	Every 5 minutes	≥18 years	Upper arm	365 days (implant)	Daily: days 2-13. Weekly: days 14+	24 hour warm up phase	Tetracycline class	Yes

CGM Device Comparison. American Association of Clinical Endocrinology. https://pro.aace.com/cgm/toolkit/cgm-device-comparison

A1c vs GMI (Glucose Management Indicator)

- A1c & GMI not expected to perfectly align
  - 19% of the time identical value
  - 51% of the time differ by 0.3%
  - 28% of the time differ by 0.5%
  - 46% of the time differ by 0.6% or more
- Difference between lab A1c and GMI remains relatively stable for an individual over time
- GMI calculated value
  - GMI (%)=3.31 + 0.02392 x (mean glucose in mg/dL)
- In general, each 25 mg/dL increase in mean glucose corresponds to GMI increase of 0.6%

Bergenstal RM, Beck RW, Close KL, et al. Glucose Management Indicator (GMI): A New Term for Estimating A1C From Continuous Glucose Monitoring. *Diabetes Care*. 2018;41(11):2275-2280. doi:10.2337/dc18-1581

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A1c vs GMI

CGM derived mean glucose (mg/dL)	GMI (%)
100	5.7
125	6.3
150	6.9
175	7.5
200	8.1
225	8.7
250	9.3
275	9.9
300	10.5
350	11.7

Bergenstal RM, Beck RW, Close KL, et al. Glucose Management Indicator (GMI): A New Term for Estimating A1C From Continuous Glucose Monitoring. *Diabetes Care*. 2018;41(11):2275-2280. doi:10.2337/dc18-1581

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Accuracy of CGMs

- Traditionally measured by MARD (Mean Absolute Relative Difference), <10% is the goal
  - Libre 3: 7.9%
    - Single study 100 patients ≥6 years
  - Dexcom G7: 8.7% for adults, 8.5% pediatrics
    - Manufacturer data
  - Hospitalized patients admitted for diabetes hyperglycemic emergencies: 10.8%
    - Single study, adults
    - FreeStyle Libre 2 & 3

-Alva S, Brazg R, Castorino K, Kipnes M, Liljenquist DR, Liu H. Accuracy of the Third Generation of a 14-Day Continuous Glucose Monitoring System. *Diabetes Ther*. 2023;14(4):767-776. doi:10.1007/s13300-023-01385-6

-Dexcom. Dexcom G7 User Guide. Published 2024. Accessed Jan 4, 2026. https://s3.us-west-2.amazonaws.com/dexcompdf/G7/AW-00046-06_UG_G7_OUS_en_MGDL.pdf

-van Baal L, Heinemann L, Reinold J, et al. Accuracy and Reliability of Intermittent Scanning and Real-Time Continuous Glucose Monitoring Systems in Diabetes Emergencies. *Journal of Diabetes Science and Technology*. 2025;0(0). doi:10.1177/19322968251334633

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Differences between CGM and Glucometer Readings

- Hand Cleanliness
- Pressure on sensor
- Medications/supplements
  - False lows: salicylic acid
  - False highs: hydroxyurea, APAP/paracetamol, vitamin C
- Rapid glucose change
  - Blood glucose changes before interstitial fluid
- Test strips
  - Expired or not stored properly
- **Sensor's first day**
  - **Gets closer over the first 24 hours**

-*Why BGM and CGM readings are sometimes different.* Dexcom. Accessed Jan 4, 2026. https://www.dexcom.com/all-access/clinical-corner/cgm-vs-bgm

-Heinemann L. Interferences With CGM Systems: Practical Relevance?. J Diabetes Sci Technol. 2022;16(2):271-274. doi:10.1177/19322968211065065

-Setford SJ. The Impact of Interfering Substances on Continuous Glucose Monitors: Part 2: Marketed CGM Designs, Labeled Interfering Substances, and Design Mitigations. *J Diabetes Sci Technol.* Published online October 16, 2025. doi:10.1177/19322968251377008

Medicare Coverage

- Type 1 or Type 2 diabetes with any insulin use and/or "problematic hypoglycemia"
  - Documentation of 2 or more episodes of level 2 hypoglycemia (glucose <54 mg/dL) despite multiple efforts to adjust medications/treatment plan or 1 episode of level 3 hypoglycemia (glucose <54 mg/dL and altered mental and/or physical state that requires third-party assistance for treatment
- Patient or caregiver trained in use of CGM (prescription for CGM serves as evidence)
- Needs to be seen in person or telehealth within past 6 months
- Considered DME, Part B coverage
  - Co-pay, deductible may apply

OSER SM, OSER TK. Medicare Coverage of Continuous Glucose Monitoring — 2023 Updates. *Family Practice Management*. 2024;31(1):17-18. Accessed January 7, 2026. https://www.aafp.org/pubs/fpm/issues/2024/0100/continuous-glucose-monitoring.html#fpm20240100p17-f1

Insurance Medicaid Coverage

- Oregon Health Plan
  - Short or intermediate acting Insulin use for Type 1, Type 2 or gestational diabetes with A1c ≥8% in the past 3 months (or prior to CGM use), frequent or severe hypoglycemia or diabetes related complications (peripheral neuropathy, CVD, end-organ damage, etc)
- Washington Medicaid
  - Type 1 Diabetes
  - Type 2 diabetes on insulin AND unable to achieve 'target' A1c OR severe hypoglycemia <50 or symptomatic OR have hypoglycemia unawareness
  - Pregnant individuals with Type 1, 2 or gestational diabetes

-*Health Technology Clinical Committee FINAL Findings and Decision Topic: Continuous Glucose Monitoring*. Accessed January 3, 2026. https://www.hca.wa.gov/assets/program/cgm-final-findings-and-decision-2025.pdf
-*Continuous Glucose Monitoring (CGM)*. https://www.orpdl.org/durm/PA_Docs/continuousglucosemonitoring.pdf

OHSU

Thank You