

Moving from Data Analysis to Action

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Moving from Data Access and Analysis to Clinical Action:
Steps to Effective Use of CGM in Primary Care (CGM:AAA)

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Disclosures

- **I have no personal financial disclosures**
- My employer, the non-profit HealthPartners Institute, contracts for my services, and I receive no personal income from the following activities:

I have participated in clinical research, been a member of a scientific advisory board, and served as a consultant for:

- Abbott Diabetes Care, Ascensia, Bigfoot Biomedical, Inc., CeQur, Dexcom, Eli Lilly, Embecta, Hygieia, Insulet, Mannkind, Medtronic, Medscape, NCQA, Novo Nordisk, Onduo, Roche Diabetes Care, Sanofi, Tandem, United Healthcare, Vertex Pharmaceuticals and Zealand Pharma
- HealthPartners Institute holds a patent for display screen with graphical user interface
- HealthPartners Institute receives NIH/NIDDK and PCORI funding

CGM is Transforming Diabetes Care

Addressing Gaps, Challenges, and Opportunities

Effective Implementation of CGM in Primary Care (where 90% of people with diabetes are seen)

Gap & Challenge

PERSPECTIVE

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Death by a Thousand Cuts — The Crushing Weight of Nonclinical Demands in Primary Care

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Opportunity

AAA Workflow & Clinical Intelligence

Steps to the Effective Implementation of CGM in Primary Care:

Workflow: AAA / Clinical Intelligence

Approval & Initiation - CGM Smart Order Set (SOS) *that facilitates:*

1. CGM prescription, approval, billing codes, management guide for patients and clinicians

Access & Reporting

1. **CGM in EHR**
2. Diabetes **Dashboard**: reporting (GMI to NCQA), population health tracking

Action & Follow-up

CCGM (Clinician CGM Guided Management) SOS tool / Clinical Intelligence

1. **Suggest treatment approach** for those on insulin based on **TIR and TBR category**
2. Follow-up: ≈4 wk. (virtual, Face to Face, asynchronous)

Clinician CGM Guided Management: For Patients on Basal Insulin

	TIR/TBR Category	Action	Medication Adjustment Considerations
1	Time in range >70% and Time below range <3%	Continue regimen	Continue to optimize current therapy; reinforce lifestyle changes and taking medications as prescribed; consider increasing basal insulin by 5% if no low glucose on AGP curve* Follow-up: 3-4 months
2	Time in range >70% and Time below range ≥3%	Address hypoglycemia	Stop sulfonylurea if present; if TBR is >10% also decrease basal insulin dose by 10% If not on sulfonylurea, decrease basal insulin by 10% if TBR ≤10% and by 20% if TBR>10% Follow-up: 2-4 weeks
3	Time in range ≤70% and Time below range <3%	Address hyperglycemia	Start or increase dose of GLP-1 RA or GIP/GLP-1 RA AND if TIR is 50-70% either stop sulfonylurea (if present), or decrease basal insulin dose by 20% If GLP-1 RA or GIP/GLP-1RA not started, or on max tolerated dose: increase basal insulin by 20% if TIR <30%, otherwise increase basal insulin by 10% • If glucose is low overnight* after looking at AGP curve, maintain current basal insulin dose and refer to diabetes education or endocrinology for regimen assessment and adjustment Follow-up: 2-4 weeks
4	Time in range ≤70% and Time below range ≥3%	Address hypoglycemia today; also refer to diabetes education or endocrinology	To minimize hypoglycemia today: • Stop sulfonylurea if present AND if TBR is >10% also decrease basal insulin dose by 10% • If not on sulfonylurea, decrease basal insulin by 10% if TBR is ≤10% and by 20% if TBR >10% Work in conjunction with diabetes education or endocrinology based on local resources to improve hyperglycemia Options to treat hyperglycemia include: • Start or increase GLP-1 RA or GIP/GLP-1 RA (preferred) • Or add mealtime bolus insulin at 1, 2, or all meals (see Table A) Follow-up: 2-4 weeks



Analysis to ACTION

- Approval
- Access
- Action

Thank
You