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An Update to Continuous Glucose Monitoring: Interpreting the Data 2025

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Introduction

With the influx of new technological tools to assist in diabetes management, health care professionals (HCPs) need to gain a working knowledge of popular devices that support people with diabetes (PWDs) in striving to achieve and maintain glucose goals and reduce their risk of diabetes-related complications. The mainstays of diabetes care and education to inform treatment adjustments have evolved beyond focusing on lifestyle modifications, using antihyperglycemic pharmacologic agents, and glucose monitoring, including blood glucose monitoring (BGM) and continuous glucose monitoring (CGM) (Elsayed, McCoy, Aleppo, et al., 2025a). This supplement updates the role of case managers in incorporating CGM in diabetes care and introduces newly approved devices. We discuss how to educate and support PWD in reviewing CGM data with their health care team to develop healthier behaviors, improve glycemic outcomes, and, ultimately, enhance quality of life.

Benefits of Choosing a Continuous Glucose Monitoring Device vs. a Blood Glucose Meter

In recent years, numerous clinicians and PWD have discovered the value of CGM over the gold standard of a BGM. The fundamental difference between using a BGM and a CGM device is that a BGM provides data at a single moment in time. In contrast, CGM delivers a continuous stream of data every one to five minutes throughout the day and night (Elsayed, McCoy, Aleppo, et al., 2025a). Historically, most people with type 2 diabetes (T2D) checked capillary glucose only once or twice a day, but wearing a CGM device greatly increases the ability to identify key patterns, such as postprandial rises and nocturnal hypoglycemia, that require changes in therapy and self-management changes, such as eating a more balanced diet and adjusting physical activity and medication schedules (Edelman, 2018; Janapala, 2019; Martens, et al., 2025). Another unique benefit of CGM is the opportunity to predict and take action to prevent hypo- or hyperglycemia through the use of trend arrows and customizable alerts and alarms (Longo, 2019). Because HCPs use CGM systems to guide in-the-moment treatment and long-term therapeutic management decisions, the American Diabetes Association (ADA) supports early initiation of CGM in PWD who are receiving insulin therapy (Elsayed, McCoy, Aleppo, et al., 2025a).

The Dexcom G7, Senseonics Eversense E365, Freestyle Libre 3 Plus, and Medtronic Guardian Sensor 4 rtCGM systems transmit glucose data continuously every one to five minutes to a receiver or other connected device such as a smartphone (Table 1). Similarly, data from observational and retrospective studies with intermittently scanned CGM (isCGM) show A1c reductions in multiple daily injections, basal insulin, and basal insulin plus noninsulin therapies in adults with T2D (Elsayed, McCoy, Aleppo, et al., 2025a). In the past, the Abbott Freestyle CGM systems (Freestyle Libre 14-day, Libre 2) were limited to isCGM systems that required the wearer to scan the glucose sensor to view the glucose data in a reader or other connected device such as a smartphone. The Freestyle Libre 3 Plus is a real-time continuous glucose monitoring (rtCGM) device that sends real-time data and optional alarms to a compatible smartphone every minute (FDA, 2022).

How Does CGM Work?

CGM measures glucose levels in interstitial fluid via a glucose sensor placed in the subcutaneous tissue just beneath the skin. When a new sensor is placed, there is a brief warm-up period that varies by device. During this warm-up period, no data are displayed until the sensor is ready to provide reliable results (Edelman, 2018). Additionally, the Eversense E365 requires calibration with a fingerstick blood sample to test blood glucose, ensuring accuracy during the initial few days and weeks. Because CGMs measure interstitial fluid instead of blood, there may be a lag time of several minutes when the glucose levels are rapidly rising or falling, such as after eating and during and after physical activity (Ajjan, 2018). Of note, no CGM system has been cleared by the FDA for use in dialysis or hospitalized patients. The Dexcom G7 and the Freestyle Libre 2 Plus and 3 Plus are not FDA contraindicated for use in pregnancy (Elsayed, McCoy, Aleppo, et al., 2025b). See Table 1 to compare features of commercially available CGM devices in the United States.

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TABLE 1 **COMMERCIALLY APPROVED PERSONAL CGM SYSTEMS**

CGM system	Dexcom G7	Eversense E365	FreeStyle Libre 2 Plus	FreeStyle Libre 3 Plus	Guardian Sensor 4
Company	Dexcom	Senseonics Ascensia Diabetes Care	Abbott	Abbott	Medtronic
Sensor	Yes	Yes, inserted by HCP	Yes	Yes	Yes
Warm-up period	30 minutes	24 hours	1 hour	1 hour	2 hours
Sensor wear time	10 days plus, additional 12-hour grace period	Up to 365 days	15 days	15 days	7 days
Transmitter	Yes, built into the sensor	Yes, removable, rechargeable	Yes, built into the sensor	Yes, built into the sensor	Yes, 1 year, rechargeable
Receiver	Yes, or you can use compatible device	Mobile receiver only	Yes, or can use compatible device	Yes, or can use compatible device	Compatible insulin pump with mobile app to view CGM data
Alerts	Yes	Yes	Yes	Yes	Yes
Nonadjunctive indication (can make treatment decisions without a BGM)	Yes	Yes, if following proper calibration guidelines	Yes	Yes	No, do not use CGM to make treatment decisions if insulin pump is in manual mode; you can always utilize confirmatory BGM as needed
Calibrations required?	No, but can calibrate if needed	Yes Initialization Phase: 4 fingerstick calibrations, spaced 2 to 12 hours apart 1 Daily Calibration Phase: fingerstick calibration every 24 hours for 13 days 1 Weekly Calibration Phase: fingerstick calibration once a week	No	No	No, but can calibrate if needed
Adult MARD	8.2%	8.8%	8.2%	8.2%	8.7%–10.6%
Integration with insulin pump	Yes	No	Yes	Yes	Yes
How often system measures glucose levels	Every 5 minutes	Every 5 minutes	Every 1 minute	Every 1 minute	Every 5 minutes
Age of approved indication (years)	≥2	≥18	≥2	≥2	≥2
Approved for use in pregnancy *(Elsayed, McCoy, Aleppo, et al., 2025b)*	Yes	No	Yes	Yes	No

Abbreviations: BGM, blood glucose monitoring; GDM, gestational diabetes mellitus; HCP, health care professional; MARD, mean absolute relative difference.

Can CGM Be Used to Dose Insulin?

The FDA has labeled some CGMs as "nonadjunctive" or therapeutic based on performance data, meaning the wearer can safely use CGM data to make treatment decisions such as dosing insulin or treating hypoglycemia. Currently, Abbott FreeStyle Libre CGMs, the Dexcom G6 and G7, and Senseonics Eversense E365 have nonadjunctive clearance. In contrast, an adjunctive CGM requires confirmation with a BGM before making treatment decisions (Edelman, 2018). Currently, the FDA has not cleared any CGM device for use in the inpatient setting. Numerous studies have been conducted since the onset of the COVID-19 pandemic to ultimately gain FDA approval. To date, the ADA recommends continuing use of CGM in the inpatient setting with confirmatory point-of-care glucose fingersticks (Elsayed, McCoy, Aleppo, et al., 2025a).

Coding and Reimbursement

Commercial and public insurance companies continue to expand reimbursement for CGM and billable services, especially professional CGM, which can be anywhere from twice a year to monthly, depending on coverage. Billing codes are available for the initiation and interpretation of both professional and personal CGM using Current Procedural Terminology (CPT) codes 95249 and 95250 for startup and training (CPT code 95249 for personal CGM and 95250 for professional CGM). A prescriber can bill the CPT code 95251 for data review, data interpretation, and data-driven recommendations if a minimum of 72 hours of CGM data are available (AACE 2022; Janapala, 2019). In 2023, the Centers for Medicare and Medicaid Services (CMS) expanded CGM coverage to PWD taking any insulin or with problematic hypoglycemia (Oser & Oser, 2024).

Who Is a Candidate for Professional CGM?

The decision to monitor glucose with a BGM, and/or wear a CGM, just as for all diabetes management strategies, should be individualized (Elsayed, McCoy, Aleppo, et al., 2025a). Many reasons, including resistance to wearing a device full time, inability to correctly place the device itself, real or imagined annoyance with alerts and alarms, and out-of-pocket cost, may influence the choice by a PWD to reject wearing CGM. For those who do not want a personal CGM, using a professional CGM—intermittently and alternating with a BGM when the CGM is not worn— may be a strategy to obtain helpful data.

Professional CGM systems are available as "blinded" so that the wearer does not see any data until an HCP downloads the sensor's data and retrospectively reviews it. Dexcom also offers an "unblinded" option, allowing the PWD to view glucose data on a smartphone or tablet in real-time. The advantage of a blinded professional CGM is that the practice purchases and places the device for the PWD, and thus, the PWD does not need to learn how to use the device at that time. Unblinded professional CGM can provide the benefits of personal CGM for individuals who are not reimbursed or who would like to "test drive" CGM without committing to purchasing a personal CGM system. The power of shared decision-making when downloading and interpreting professional CGM data and making collaborative, data-driven modifications in diabetes management in real-time and retrospectively when reviewing reports can be instrumental in motivating PWD to try a personal CGM some of the time. Although blinded professional CGM data are retrospective, the ability to identify patterns of previously undetected hypo- and hyperglycemia can successfully inform data-driven changes in meals, physical activity, and initiation, titration, and timing of diabetes medications (Elsayed, McCoy, Aleppo, et al., 2025a). See Table 2 for more information about professional CGM in the United States.

TABLE 2 PROFESSIONAL CGM

CGM system	Dexcom Pro
Blinded vs unblinded	Option for use blinded or unblinded with smart device
Sensor wear	10 days
Glucose alerts and alarms	Yes, if connected to smart device with unblinded option
Calibration required	No

Who Is a Candidate for a Personal CGM?

Personal CGMs should be offered to PWD across the lifespan. Historically, personal CGMs were prioritized for individuals with type 1 diabetes (T1D) or type 2 diabetes (T2D) and on multiple daily injection insulin therapy. However, individuals with T2D who are on basal insulin therapy and oral medications also benefit from CGM. Additionally, the ADA recommends that CGM therapy be offered to individuals with T1D at diagnosis or as soon as possible afterward. (Elsayed, McCoy, Aleppo, et al., 2025a). Furthermore, the FDA has recently approved several personal CGMs for pregnancy and gestational diabetes, and CGM therapy is recommended by the ADA for pregestational T1D (Elsayed, McCoy, Aleppo, et al., 2025b). Most CGMs are worn 7 to 15 days, with the exception of the Senseonics Eversense E365, which is inserted completely under the skin by an HCP and worn for up to 365 days. Unlike a blinded professional CGM, a personal CGM will continuously transmit glucose data to a personal receiver, insulin pump receiver, smartphone, smartwatch, or other compatible device and can sound alerts and alarms as well as vibrate in response to rapidly changing glucose levels and preset glucose thresholds (Elsayed, McCoy, Aleppo, et al., 2025a). CGM systems that use a smart device to display glucose data can share glucose data remotely with family members, caregivers, and HCPs. Determining which CGM system to use is a personalized decision made between PWD and their HCP. When an individual starts wearing a CGM, they must have a basic understanding of how to use the trend arrows, interpret the alerts and alarms, and take

appropriate actions, when needed. Over time, this education is key in motivating PWD to see the value of CGM in guiding self-care management activities daily and making long-term lifestyle and medication adjustments in collaboration with their care team.

We will discuss a standardized method of interpreting CGM data and apply this knowledge to reviewing and interpreting data downloads from two typical cases.

Downloading and Interpreting CGM Data

HCPs must be trained in interpreting CGM data to assist PWD in understanding how to use trends and patterns for treatment plan adjustments and real-time decision-making. CGM devices can manually or automatically upload the data to cloud-based platforms that can be viewed by the PWD and remotely by the HCP after the individual grants access to their data. If using a smart device to view the data, uploading can occur automatically through syncing the device with cloud-based data aggregators. If a dedicated receiver device is used to view data, it must be manually uploaded from the receiver to a computer. If an insulin pump is used as a receiver, in some cases, it can be manually uploaded from the pump to a computer, and in others, it must sync with the cloud to upload data. Most diabetes specialty clinics, some primary care offices, and maternal-fetal medicine clinics upload CGM data, as well.

Although HCPs can view CGM glucose data in a variety of reports, the most highly recognized and standardized report is the Ambulatory Glucose Profile (AGP) Report (Figure 1 and Table 3).

Before identifying patterns and making recommendations, the HCP must reconcile the CGM data report to the individual's daily schedule, noting when the individual typically sleeps, eats, takes diabetes medication, and is physically active. Encourage PWDs to interpret the data with their HCP to promote data-driven shared

FIGURE 1 AGP REPORT

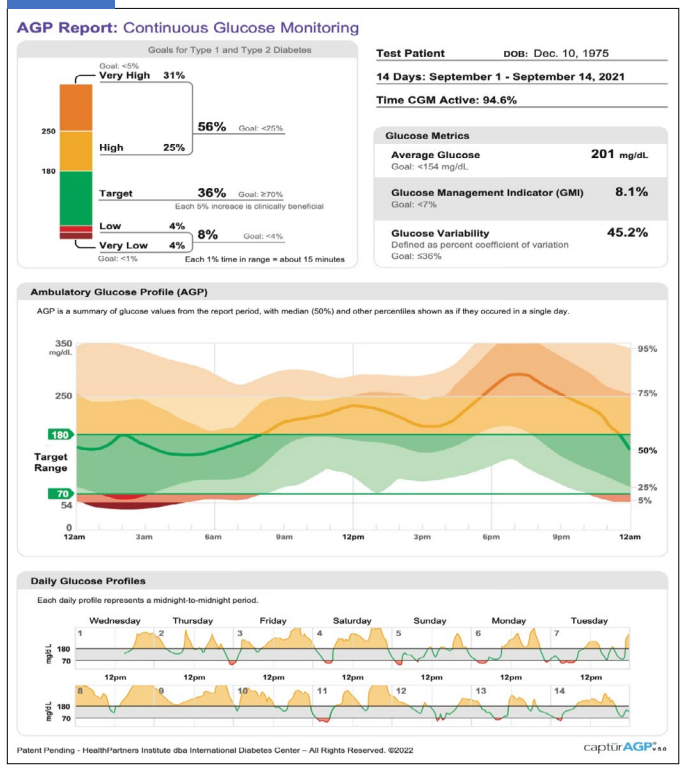

Figure 1 illustrates an example of the AGP Report (IDC, 2023; Battelino, 2019). The AGP is a standardized single-page glucose report that includes summary glucose statistics, a glucose profile graph, and individual daily glucose trend graphs (IDC, 2023). This report is integrated into proprietary CGM reporting software, helping to translate glucose data into a graphical display for quick and easy interpretation. This standardized report is similar to an electrocardiogram (ECG) report; it includes standardized metrics and should be interpreted uniformly regardless of the machine used. CGM AGP Report - v5.0 is available at http://agpreport.org/agp/agpreports

TABLE 3 PARAMETERS IN AGP REPORTS

	Definition	Target	Clinical Pearls
1: Glucose Statistics and Targets			
Percentage of time CGM active	Percentage of time the CGM was actively worn and collecting data	Active at least 70% of time	Have at least 10 days of CGM data (or 70% CGM active time) available to confidently use data for treatment decisions (Danne, 2017)
Average glucose	All glucose values are added together and divided by number of readings (mean)	<154 mg/dL	Glucose targets should be individualized (Elsayed, McCoy, et al., 2025) Mean glucose complement lab A1c and CGM metrics (Selvin, 2024)
Glucose management indicator (GMI)	Average A1c level calculated from mean sensor glucose reading	<7%	Fourteen days of CGM data provide an estimation of glucose metrics for the last 3-month period (Tozzo et al., 2024) GMI is an educational and motivational tool that allows PWDs to reflect on their anticipated A1c if the conditions during the reporting period continue for the next 2-3 months. However, GMI is often a poor estimate of A1c and should be used with mean glucose (Selvin, 2024)
Glucose variability (coefficient of variation)	Indicates how much glucose levels fluctuate throughout the day and night	<36% of the time	In general, lower glucose variability is preferred since it usually indicates less hyper- and hypoglycemia (Monnier, 2021; Zhou, 2020)

(continues)

TABLE 3 **PARAMETERS INCLUDED IN AGP REPORTS** *(continued)*

	Definition		Target	Clinical Pearls
2: Time in Glucose Ranges: Percentage of time and hours/minutes of a 24-hour day spent in glucose range				
Time above range (TAR)	Very High	>251 mg/dL	<5% of the time	Discuss frequency of missed anti-hyperglycemic medication and insulin doses and troubleshoot etiology A target of <50% TAR may be appropriate for older adults and high-risk PWDs (Battelino, 2019). Reviewing appropriate timing of mealtime medications and encouraging a balanced meal plan and regular physical activity may help reduce hyperglycemia
	High	181-250 mg/dL	<25% of the time	
Time in range	Glucose 70-180 mg/dL		>70% of the time	Time in range has become a key metric for CGM wearers to guide diabetes therapy. May be individualized to the clinical situation (i.e., target 70-140 mg/dL), although the AGP Report will always use 70-180 mg/dL as the target range. Every 5% increase in time in range has clinically significant benefits (Battelino, 2019)
Time below range	Low	55-69 mg/dL	<4% of the time	Low glucose patterns may co-occur with high glucose patterns on the same day and are often interrelated. Addressing hypoglycemia is always the priority. Discuss the timing of medications, variability in meals (timing and carbohydrate content), and the role of physical activity
	Very Low	<54 mg/dL	<1% of the time	Immediate attention required if percentage is above 1%. Often associated with cognitive impairment. Particularly dangerous for PWD and individuals with cardiovascular disease (Battelino, 2019)
3: Ambulatory Glucose Profile: Daily glucose profiles are combined to represent the glucose patterns over a single 24-hour day				
Heavy (middle) line	Represents median glucose value		Ideally mostly flat and inside the target (70-180 mg/dL)	Presents "average day"; ideally is stable and in target range
Darker shading	Represents 50% of the glucose values		Ideally is narrow	The narrower the area, the less the glycemic variability
Lighter shading	Represents 95% of glucose values		Ideally is close to darker shaded area	The wider the area, the higher the glycemic variability
Daily glucose profile	Thumbnail boxes displaying a single day's glucose pattern. Time below range is shaded red, time above range is shaded yellow			Reviewing daily profiles helps identify patterns related to variation in schedule (ie, weekends versus weekdays), changes in self-care behaviors, and stress.

Abbreviations: CGM, continuous glucose monitoring; isCGM, intermittently scanned continuous glucose monitoring.

decision-making. One helpful strategy is to draw circles around patterns directly on a copy of the AGP Report and ask PWD what they see (Johnson, 2019).

Table 3 describes each of the parameters included in the AGP Report as well as clinical pearls for interpreting the data.

Before beginning to identify patterns and make recommendations, orient the CGM data report with the individual's daily schedule, noting when the individual typically sleeps, eats, takes diabetes medication, and is physically active. PWD should be encouraged to interpret the data with their HCP to promote data-driven shared decision-making.

Steps for Assessing CGM Data

The following steps are illustrated in Table 4 in a simpler format.

Step 1: Assess for adequacy of data. Recommendations are that CGM be used for at least 70% of the time or about 10 of the 14 days included in the AGP Report (Battelino, 2019). If data collected are insufficient, gaps in the AGP graph will exist. In this example, a PWD is using an is CGM (Libre 2+ if used without pump integration). You can see in the Daily Glucose Profiles (see Figure 1) that the individual is scanning 1–2 times per day, resulting in the CGM being active 45% of the time. Because the amount of sensor data is inadequate, the glucose management indicator (GMI) was

TABLE 4 SIMPLE STEPS TO INTERPRET CGM DATA

Step 1	Assess for adequacy of data
Step 2	Assess for hypoglycemia
Step 3	Review overnight trends and patterns
Step 4	Assess for hyperglycemia
Step 5	Assess for glycemic variability
Step 6	Develop an action plan using data-driven shared decision-making

Source: Minimed 2017, Dexcom 2022, Abbott 2021

not calculated, and care should be taken when evaluating all of the metrics for therapy changes. This AGP Report example can still be useful for counseling about the significant postprandial rise seen on several daily graphs.

Step 2: Assess for patterns of hypoglycemia. Review the results and targets for time spent in hypoglycemia. When reviewing the AGP Report, remember that if the lighter shading is touching or below 70 mg/dL, this indicates at least 5% of all glucose values are <70 mg/dL during that time. Immediate action is needed to address hypoglycemia if the darker shading is touching or below the 70 mg/dL line or the lighter shading touches 54 mg/dL (Johnson, 2019). It is important to assess hypoglycemia reported by the PWD and to review the daily glucose profiles together to determine if hypoglycemia occurs on particular days (i.e., weekend versus weekdays) or following periods of hyperglycemia or physical activity.

Step 3: Review overnight trends and patterns. Ideally the glucose is stable and in target range. For PWD who are overtreated with basal insulin (i.e., glargine, detemir, degludec), you may see a downtrend overnight with an accompanying increased risk of nocturnal hypoglycemia (Cowart, 2020). Fasting hyperglycemia may be the result of rebound from overnight hypoglycemia, an effect called the Somogyi phenomenon (Klonoff, 2016). CGM has been proven to reduce or prevent nocturnal hypoglycemia (Olafsdottir, 2018).

Step 4: Assess for hyperglycemia. Discuss meal choices and portion sizes, timing of diabetes medications (premeal, postmeal, or missed), and stress if there is a large amount of glucose variability (wider area of shading). It can be helpful to assess the daily glucose profile to review specific examples.

Step 5: Assess for glycemic variability. Reviewing the daily glucose profiles may be helpful in identifying key contributing factors to variation in glucose levels.

Step 6: Set goals and make an individualized and mutually agreed upon follow-up plan for adjustment in therapy. People with diabetes may be motivated by the knowledge that a 10% increase in time in range can translate into a 0.5% decrease in A1c, a clinically meaningful benefit (Battelino, 2019).

Case Study 1

Mr. G is living in assisted living, and his diabetes management plan includes metformin 850 mg by mouth (PO) twice daily and glargine 35 units subcutaneously at 9 pm. His A1c has remained between 8% and 8.5% despite an increase in his glargine insulin dose. Mr. G requires assistance from his wife, who checks his fasting blood glucose daily and reports a blood glucose range of 90 to 35 mg/dL. To learn more about Mr. G's blood glucose levels throughout the day and night, a professional CGM system was placed in the practice with the following report (Box 1) that we can review:

BOX 1 CGM REPORT

Start with a stepwise approach to reviewing data:

- Assess for adequate amount of data for use: Yes, 97% (Goal is >70%)
- Assess for hypoglycemia: Yes, nocturnal hypoglycemia after a steady decline in glucose overnight. (Goal <4% low, <1% very low)
- Review overnight trends and patterns: steady decline in glucose overnight with hypoglycemia
- Assess for hyperglycemia: Yes, 48% time in range (Goal >70%) with 28% high and 21% very high (Goal <25% high and <5% very high). Hyperglycemia appears to occur postprandially and is often preceded by a drop in glucose (review 12–5 am and 3–6 pm time periods in the AGP summary of glucose values graph)
- Assess glycemic variability: 44% is above target of less than % of the time. Hypoglycemia and rebound hyperglycemia are likely the causes
- Develop an action plan using data-driven shared decision-making: reduce basal insulin dose and add a glucagon-like peptide-1 receptor agonist (GLP-1 RA)

Mr. G has a sharp downtrend overnight with occasional mild hypoglycemia. His A1c is elevated due to postprandial hyperglycemia, and he is at risk for nocturnal hypoglycemia if his dinner is low in carbohydrates or if he skips dinner. After discussion with the care team and the Mr. G, his basal insulin dose is lowered to reduce overnight hypoglycemia and a GLP-1 RA (dulaglutide) is added to the diabetes management plan since a GLP-1 RA will blunt postprandial hyperglycemia without causing hypoglycemia.

Case Study 2

Mrs. E is a 52-year-old woman. She takes 25 units of glargine every night at 10 pm and 4 units of insulin aspart with each meal. She has been waking up with hypoglycemia and therefore has been skipping her morning insulin aspart dose but continues to take

Personal CGMs should be offered to PWD across the lifespan.

insulin aspart with lunch and supper. Mrs. E began wearing a CGM but does not have alarms enabled out of fear of interrupting her partner's sleep.

BOX 2 REVIEW OF DATA

- Assess for adequate active CGM data: Yes, 100% of the time
- Assess for hypoglycemia: fasting hypoglycemia 4% of the time below 54 mg/dL (Goal less than 1%) calls for immediate action. Note the frequent steady decline in glucose overnight
- Review overnight trends and patterns: steady decline overnight
- Assess for hyperglycemia: consistent pattern of rebound hyperglycemia following hypoglycemia
- Assess glycemic variability: 38% is above target of less than 36% of the time. Fasting hypoglycemia with subsequent post-breakfast rise as well as variability of glucose in the evening may be contributing
- Develop an action plan using data-driven, shared decision-making: reduce basal insulin, educate about the need for prandial insulin dosing after correcting hypoglycemia to above 70 mg/dL with 15 grams of fast-acting carbohydrate

As you can see, Mrs. E is experiencing fasting hypoglycemia. As a result, she skipped her breakfast prandial insulin dose, which led to significant postmeal hyperglycemia. You work with Mrs. E and her care team and agree to reduce her glargine dose to reduce fasting hypoglycemia. You educate Mrs. E on the importance of treating hypoglycemia first and then taking mealtime insulin at the start of her meal. Mrs. E and her partner discuss the importance of prevention, early identification, and treatment of hypoglycemia with you while you assist in enabling hypoglycemia alarms in the CGM. This process illustrates that using CGM and shared decision-making can empower PWD to understand glucose trends, make "smart" treatment decisions in real time, and improve quality of life.

Conclusion

Despite the many advantages of using CGM data to guide diabetes management, the adoption of CGM among people with T2D who do not receive their health care from diabetes specialists remains limited. We hope that this paper will be a call to action for care managers to be advocates for personal and professional CGM for PWD, caregivers, and the health care team. Care managers are perfectly positioned to identify PWD who could benefit from CGM and assess their willingness to try it. During the process of downloading and interpreting the data, the case manager will help unlock the power of CGM as a dynamic tool to manage diabetes effectively. ■

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An Update to Continuous Glucose Monitoring: Interpreting the Data 2025

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Questions

1. **Which of the following are benefits of CGM?**
   a. Identification of glucose patterns
   b. Ability to predict and take action
   c. Fewer finger sticks
   d. All of the above
2. **CGM measures glucose levels in interstitial fluid via a glucose sensor placed in the subcutaneous tissue just under the skin.**
   a. True
   b. False
3. **The American Diabetes Association supports early initiation of CGM for individuals with diabetes who are receiving insulin therapy.**
   a. True
   b. False
4. **The FDA has labeled some CGMs as "nonadjunctive" or therapeutic based on performance data, meaning the wearer can safely use CGM data to make treatment decisions, such as taking insulin or treating hypoglycemia.**
   a. True
   b. False
5. **Barriers to use of CGM include which of the following?**
   a. Resistance to wearing a device full time
   b. Inability to correctly place and manage the device
   c. Real or imagined annoyance with alerts or alarms
   d. All of the above
6. **Which of the following may be candidates for CGM?**
   a. Type 1 PWD on multiple daily insulin injections
   b. Type 2 PWD on multiple daily insulin
   c. Gestational diabetics
   d. All of the above
7. **The Ambulatory Glucose Profile Report contains which of the following information?**
   a. Summary of glucose statistics
   b. Individual glucose trends
   c. Glucose profile graph
   d. All of the above
8. **The CGM data report should be oriented to which of the individual's daily schedule?**
   a. Sleeping
   b. Eating
   c. Physical activity
   d. All of the above
9. **Which of these steps are followed in interpreting CGM data?**
   a. Assess for adequacy of data
   b. Assess for hypoglycemia
   c. Review for overnight trends and patterns
   d. All of the above
10. **Using CGM data to set goals can improve clinical outcomes and decrease A1c.**
    a. True
    b. False

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An Update to Continuous Glucose Monitoring: Interpreting the Data 2025

Objectives

1. State three benefits of using continuous glucose monitoring (CGM).
2. Describe the Ambulatory Glucose Profile Report.
3. Define three steps in interpreting CGM data.

Answers

Please indicate your answer by filling in in the letter:

1. _____ 2._____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10._____

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