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Key CGM Recommendations from ADA 2026 SOC

Standards of Care in Diabetes—2026

American Diabetes Association

OBJECTIVE **Highlight the key updates and clinical takeaways from the 2026 ADA Standards of Care to guide clinicians in optimizing patient outcomes with CGM technology.**

All Diabetes

- 7.15 – 2026 Update: **Use of CGM is recommended at diabetes onset and anytime thereafter for children, adolescents, and adults with diabetes who are on insulin therapy,** A on noninsulin therapies that can cause hypoglycemia, C and on any diabetes treatment where CGM helps in management. C The specific CGM device and method for use should be made based on the individual's circumstances, preferences, and needs. E

Type 1 Diabetes

- 3.2 – In people with presymptomatic T1D, monitor for disease progression using A1C approximately every 6 months and 75-g OGTT annually; modify frequency of monitoring and **consider augmenting with other glycemic assessment tools such as CGM metrics** based on individual risk assessment incorporating age, number and type of autoantibodies, and glycemic metrics. E

Prediabetes

- 1.8 – 2026 Update: Provide people with diabetes additional self-management support from lay health coaches, navigators, or community health workers when available. A **Digital self-management tools or coaches may be considered as appropriate.** B

Pregnancy

- 15.10 – **Continuous glucose monitoring (CGM) can help to achieve glycemic goals (e.g., time in range, time above range)** A and A1C goal B in type 1 diabetes and pregnancy and may be beneficial for other types of diabetes in pregnancy. E
- 15.11 – **Recommend CGM to pregnant individuals with type 1 diabetes.** A In conjunction with aims to achieve traditional pre- and postprandial glycemic goals, **CGM can reduce the risk for large-for-gestational-age infants and neonatal hypoglycemia in pregnancy** complicated by type 1 diabetes. A

Pediatrics

- 14.16 – 2026 Update: **CGM should be offered for diabetes management at diagnosis or as soon as possible in children and adolescents with diabetes who are capable of using the device safely (either by themselves or with caregivers).** A The choice of device should be made based on the individual's and family's circumstances, desires, and needs.

Older Adults

- 13.5 – 2026 Update: **Recommend CGM for older adults with type 1 diabetes** A **and type 2 diabetes on insulin therapy** B **to improve glycemic outcomes, reduce hypoglycemia, and reduce treatment burden.**

Hypoglycemia

- 6.14 – **Use of CGM is beneficial and recommended for individuals at high risk for hypoglycemia.** A

CGM Access

- 7.16 – **In people with diabetes on insulin therapy, CGM devices should be used as close to daily as possible for maximal benefit.** A **People with diabetes should have uninterrupted access to their supplies to minimize gaps in CGM.** A

AID

- 7.8 – **Consider early initiation, including at diagnosis, of CGM, CSII, and AID depending on a person's or caregiver's needs and preferences.** C

Diabetes Care 2026; Supplement - DiabetesJournals.org/care ADA

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OBJECTIVE Highlight the key updates and clinical takeaways from the 2026 ADA Standards of Care to guide clinicians in optimizing patient outcomes with CGM technology.

Key Takeaways

1. **CGM eligibility broadened** – Recommended at diabetes onset and anytime thereafter for people on insulin therapy A, those on noninsulin therapies that can cause hypoglycemia C, and any diabetes treatment where CGM helps in management. (7.15)
2. **Pregnancy** – Recommend CGM for pregnant individuals with type 1 diabetes to improve outcomes and reduce neonatal risks. A (15.11)
3. **Pediatrics** – Offer CGM at or soon after diagnosis for children and adolescents able to use it safely; personalize device choice. A (14.16, 2026 Update)
4. **Adherence and access** – Use CGM as close to daily as possible for maximal benefit and ensure uninterrupted access to supplies. A (7.16)
5. **AID initiation simplified** – Consider early initiation, including at diagnosis, of CGM, CSII, and AID depending on a person's or caregiver's needs and preferences. C (7.8)

Evidence Grading System

A. Strong evidence from well-conducted, generalizable RCTs, multicenter trials, or meta-analyses.

B. Supportive evidence from well-conducted cohort studies, case-control studies, or meta-analyses.

C. Supportive evidence from poorly controlled or uncontrolled studies, including flawed RCTs, observational studies, or case reports.

E. Expert consensus or clinical experience.