

# Project ECHO®: Continuous Glucose Monitoring (CGM) in Gestational Diabetes: A Focus in South Dakota



## Case Presentation

33 year-old female (G/P 8/4) with history GDM past 2 pregnancies now with T2D current pregnancy at 37.1 week complicated by obesity, pyelonephritis, kidney stones s/p stents



**QUESTION:** Should NPH insulin be added on? What should diabetes management be after delivery?

**Past Pregnancy Hx:**

- 2018 IUGR, 2019 A2 GDM, 2020 A2 GDM, 2022 no GDM, 2025 T2D

**Diabetes HX**

- GDM x 2 pregnancies and then dx T2D ~1 years ago

**Diabetes Management**

- Nutrition therapy: RD following with GDM team
- Medications: Metformin → Basal insulin only (Glargine 12u) → Bolus insulin only (Aspart 4-6-6 units with meals) +/- considering NPH

**Glycemic Monitoring & Data:** Libre 3

- Fasting pattern: <95
- Post-prandial pattern: mild post-prandial hyperglycemia- overall well controlled

**Social & Structural Factors**

- Difficult to get fingerstick from her during prior pregnancies. Busy with kids at home and difficult pregnancy with kidney stones/pain.
- Insurance: Private, eligible for Medicaid

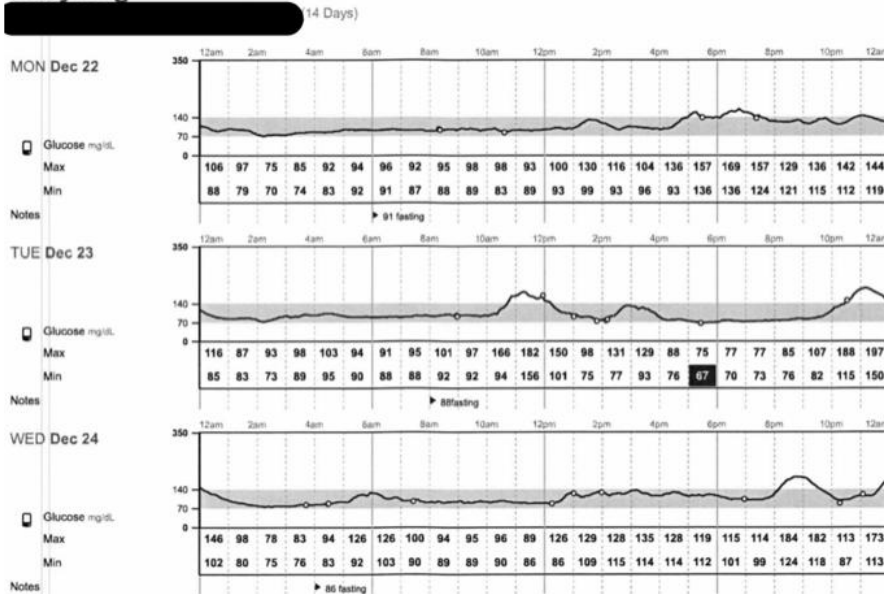
**Cardiometabolic risk profile disease:**

- Obesity: yes
- CKD: ? (Complicated by chronic kidney stones)
- ASCVD: no
- Heart Failure: no
- Hypertension: no
- Hypercholesterolemia: no



## Daily Log

LibreView



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TOPIC / FOCUS AREA	CASE RECOMMENDATIONS
Social Determinants of Health (SDOH)	<ul style="list-style-type: none"> <li>Do not start with the device. Start with whether the patient can realistically use it.</li> <li>Address behavioral and emotional responses to CGM data early.</li> <li>Normalize screening for social determinants of health early, including phone/data access, transportation, food insecurity, and health literacy.</li> <li>Align CGM selection with Medicaid formulary and pharmacy workflows prior to prescribing to avoid delays.</li> <li>Provide low-tech alternatives when needed (paper logs, phone follow-up).</li> <li>Utilize team members (RN, MA, PharmD, care coordinators) to assist with CGM onboarding and troubleshooting.</li> <li>Simplify CGM education and data review for patients with limited tech access.</li> <li>Reinforce that CGM can reduce visit burden when implemented thoughtfully.</li> </ul>
Behavioral Health	<ul style="list-style-type: none"> <li>Set expectations early that CGM reflects trends, not perfection. More data can increase anxiety if expectations are not set early.</li> <li>Address behavioral and emotional responses to CGM data early. Patients may feel they are failing when seeing frequent highs. Reframe CGM as a learning tool.</li> <li>Reduce alarm fatigue by adjusting alert thresholds appropriately.</li> <li>Use supportive, non-judgmental/non-punitive language when reviewing glucose data.</li> <li>Consider referral to Diabetes Self-Management Education &amp; Support (DSMES) or behavioral health when distress is present.</li> </ul>
Glucose Monitoring, Set A1C + Glycemic Goals	<ul style="list-style-type: none"> <li>Avoid relying on HbA1c alone in pregnancy.</li> <li>Emphasize post-prandial hyperglycemia as a key driver of outcomes.</li> <li>Focus CGM review on Time Above Range, not perfection.</li> <li>Reinforce pregnancy targets (not non-pregnant CGM defaults) and SHOW your patients how to modify targets/reports.</li> </ul>
Diabetes Self-Management Education (DSMES) &	<ul style="list-style-type: none"> <li>Set expectations for frequency of CGM review (e.g., weekly patterns, not daily micromanagement).</li> <li>Use simple frameworks such as reviewing what was eaten and what happened</li> </ul>

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Support	<p>afterward.</p> <ul style="list-style-type: none"> <li>• Leverage patient-friendly resources (e.g., <a href="#">diaTribe</a>)</li> <li>• Without coaching, CGM data can become overwhelming rather than helpful.</li> <li>• CGM amplifies education — it doesn't replace it.</li> </ul>
Risk Reduction	<ul style="list-style-type: none"> <li>• Risk reduction in GDM starts before complications appear.</li> <li>• Use CGM trends to guide early intervention, not late escalation.</li> <li>• Reinforce nutrition timing, carbohydrate quality, and post-meal physical activity.</li> <li>• Encourage light activity (e.g., walking) after meals.</li> <li>• CGM use can help reduce hypoglycemia and NICU admissions.</li> <li>• Begin postpartum planning early, including glucose testing and long-term risk counseling.</li> </ul>
Pharmacy considerations	<ul style="list-style-type: none"> <li>• Simplify regimens when possible.</li> <li>• Utilize PharmD support for CGM interpretation and rapid-cycle titration.</li> <li>• Small timing adjustments often matter more than dose increases.</li> <li>• Focus on insulin timing rather than dose escalation. Reinforce correct insulin timing for post-prandial control.</li> <li>• Ensure medication and CGM coverage continuity through delivery.</li> </ul>
Systems and Workflow Considerations	<ul style="list-style-type: none"> <li>• Workflow, not technology, is often the limiting factor. Successful programs rely on standardized, team-based processes rather than individual clinicians.</li> <li>• Define clear roles for CGM placement, education, and data review.</li> <li>• Standardize workflows for CGM onboarding and follow-up.</li> <li>• Ensure CGM data is shared across the care team.</li> <li>• Avoid siloed data review; promote team-based interpretation.</li> </ul>
Medication Therapy & Adjustments	<ul style="list-style-type: none"> <li>• CGM can enables safer, more precise titration.</li> <li>• Base therapy adjustments on patterns rather than individual readings.</li> <li>• Clearly distinguish between fasting and post-prandial glucose issues.</li> <li>• Prioritize management of post-prandial hyperglycemia.</li> </ul>

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	<ul style="list-style-type: none"> <li>• Avoid overtreatment and hypoglycemia.</li> </ul>
Post Partum Recommendations	<ul style="list-style-type: none"> <li>• Postpartum follow-up should be planned during pregnancy, as it is often missed.</li> <li>• Discontinue insulin postpartum as clinically appropriate.</li> <li>• Monitor glucose levels in the immediate postpartum period.</li> <li>• Provide counseling on long-term risk of type 2 diabetes.</li> <li>• Consider short-term CGM use postpartum in high-risk patients.</li> <li>• If T2D not evident immediately post-partum, encourage ongoing screening every 1 to 3 years.</li> </ul>
Hub Team Key Takeaways	<ul style="list-style-type: none"> <li>• Start with patient readiness and access, not the device.</li> <li>• Use CGM as a teaching and engagement tool rather than just for monitoring.</li> <li>• Address behavioral and emotional responses to CGM data early.</li> <li>• Focus on post-prandial glucose patterns as the primary driver of outcomes.</li> <li>• Implement team-based workflows including PharmD, nursing, and DSMES.</li> <li>• Standardize workflows, as implementation determines success more than technology.</li> <li>• Make small, frequent, pattern-based adjustments.</li> </ul>

## Gestational Diabetes Clinician & Patient Resources

### Diabetes & Pregnancy

[New International Consensus on Diabetes Technologies in Pregnancy](#)

[IHS Patient Ed: Diabetes and Pregnancy](#)

[diatribe Learn: Gestational Diabetes](#)

[ADA Gestational Diabetes Resources](#)

[ADA GDM Continuing Education Courses](#)

### Diabetes Devices

[DiabetesWise: Selecting Diabetes Devices & More](#)

[IHS Patient Ed Continuous Glucose Monitoring](#)

[Time In Range Coalition: For Patients & Healthcare Professionals](#)

[Time In Range Toolkit for Healthcare Professionals](#)

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[Podcast: Simplifying CGM Integration: A Workflow for Every Provider](#)

[Podcast: Understanding CGMs and Interpreting Data for Beginners](#)

[Podcast: Deploying the iLet Bionic Pancreas in Primary Care](#)

[American Pharmacists Association: CGM Services-Workflow Considerations](#)

[AAFP: Guidance for use of CGM in treating gestational diabetes mellitus](#)

## **Nutrition**

[Diabetes Food Hub](#)

[My Native Plate](#)