Diabetes Technology & Pregnancy

A Primary Care Primer

Primary care plays a vital role in quality diabetes care, particularly in areas where access to specialists may be limited. This is especially relevant during pregnancy, where there are significant ethnic and geographical disparities in diabetes prevalence and outcomes .[1,2]

The 2026 ADA Standards of Care recommend that diabetes devices be offered to all people with diabetes.[3] However, there has been limited guidance on the use of technologies like continuous glucose monitoring (CGM) and automated insulin delivery (AID) during pregnancy due to insufficient research, particularly in type 2 and gestational diabetes.

New Expert Recommendations

In 2026, a groundbreaking international consensus statement was published in *The Lancet Diabetes & Endocrinology,* providing recommendations to guide the application of CGM and AID to manage type 1, type 2, and gestational diabetes during pregnancy.

The consensus was **endorsed by 24 international medical associations,** including the American College of Diabetology, American Association of Clinical Endocrinology, Association of Diabetes Care and Education Specialists, and World Organization of Family Doctors, and supported by the American College of Obstetrics and Gynecology.

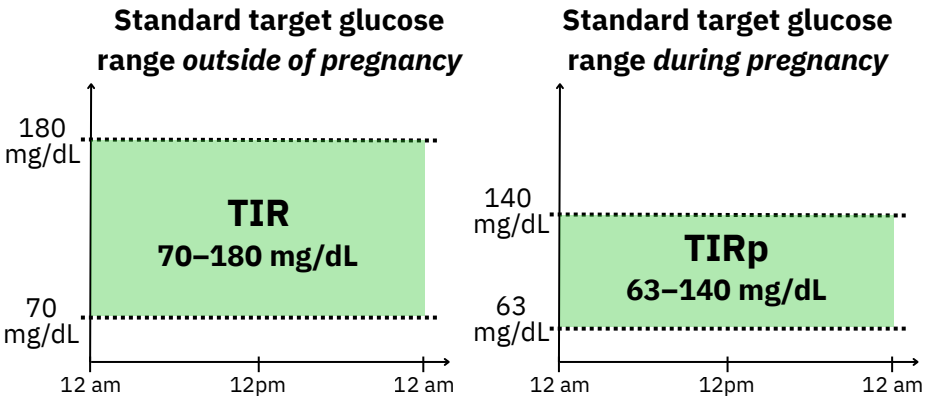
Role of Primary Care

Diabetes in pregnancy should ideally be a multidisciplinary team effort, involving coordination between primary care and endocrinology, obstetrics, maternal-fetal medicine, diabetes care and education, pharmacy, midwifery, dietitians, and other individualized support as appropriate.

While you may not be responsible for managing every detail in this document, being aware of these recommendations can help you provide consistent, up-to-date guidance—whether fielding questions about management options from someone living with diabetes and considering pregnancy, or providing education and support when specialist care is unavailable.

Target Glucose Ranges

CGM generates detailed, actionable metrics that show the full picture of diabetes management. One of these metrics is **time in range**. The recommended target range is more narrow in pregnancy:



Consensus Glycemic Targets

The chart below does not list all glycemic targets for diabetes in pregnancy, only those established or featured by the consensus recommendations.

	T1D	T2D	GDM
Planning Pregnancy	>70% TIR; >70% TIRp if possible (A) A1C <7.0%; <6.5% if possible. (A)	A1C <6.5%; <6.0% if possible[5,6]	N/A
During Pregnancy	>70% TIRp[4]	>80% TIRp (E)	>90% TIRp (E)
Intrapartum	>70% TIRp	No recommendation given	No recommendation given
Postpartum	>70% TIR	>70% TIR[4,7]	N/A

Each recommendation is assigned a level of supporting evidence (**A, B, C, or E** for expert opinion). Citations included are not intended to be comprehensive—please see the full consensus statement for greater detail.

Recommendations for Device Use

Type 1 Diabetes

CGM

- Optimize glycemia using CGM when planning pregnancy to reduce the risk of complications.[6,8] (A)
- Use CGM during pregnancy with T1D. CGM use in T1D pregnancy is associated with improved neonatal health outcomes (including reduced LGA infants, NICU admissions, and severe neonatal hypoglycemia), reduced hypertensive disorders of pregnancy, and is cost-neutral or cost-saving compared to fingerstick testing.[9–12] (A)

AID

Systems vary significantly. Device selection is recommended as follows:

- Initiate AID prior to pregnancy to optimize preconception glycemia.[3] Note recommendations for device use *in* pregnancy below, to ideally avoid the need to switch after conception. (A)
- If possible, choose a system that has **1)** evidence from an RCT *in pregnancy*, **2)** proven clinically relevant benefit (≥5% daily TIRp improvement) compared to standard insulin therapy + CGM and **3)** pregnancy-specific glucose target settings and/or algorithm that can adapt to changes in insulin sensitivity/is pregnancy-specific. . These systems can support TIRp, improve overnight glycemia, reduce hypoglycemia, and ease burden for the user.[13–15] (A)
- If a preferred AID system is not available, consider using a system with RCT evidence of clinically relevant glycemic benefits *outside of pregnancy*, with assistive settings and techniques and support from an experienced healthcare team. (B) Systems with an appropriately low glucose target setting and/or evidence of ≥5% daily improvement in TIRp are preferred. (E) Tables 2 and 3 in the consensus statement include specific setting recommendations for AID systems during **pregnancy** and **intrapartum.**
- Use of AID can be continued during labor and delivery to help maintain tight glycemia without increased risk of hypoglycemia.[16,17] (B)
- AID can safely be used postpartum, and improves glycemia compared to standard insulin delivery.[18–20] (A)
- During the 3rd trimester, provide pregnant woman and hospital team with instructions for managing AID system during labor, delivery, and postpartum. (E)

Automated Insulin Delivery (AID)

AID systems use an algorithm, insulin pump, and CGM to provide glucose-responsive insulin delivery with user-initiated pre-meal insulin boluses. Distinct from older forms of pump technology, which operate primarily on pre-programmed settings and do not automatically adjust for glucose levels.

Continuous Glucose Monitoring (CGM)

CGM tracks glucose in the interstitial fluid, providing updated levels to the user every 1 to 5 minutes. CGM allows users and their care teams to see the full picture of diabetes management—including variability, hypo- and hyperglycemic episodes, patterns, and more.

Type 2 Diabetes

- CGM can be a useful tool when preparing for pregnancy with type 2 diabetes, supporting positive changes to weight and fitness, TIRp, TIR, A1C, hypoglycemia, and other health outcomes.[21–27] (B)
- CGM can be offered during pregnancy with type 2 diabetes based on available resources and individual preferences. More evidence is needed to determine how CGM may impact pregnancy outcomes in type 2 diabetes. (E)
- Use capillary blood glucose testing for all women with T2D, and provide education to support consistent use. (A)

Gestational Diabetes

- CGM can be offered during pregnancy with gestational diabetes, based on available resources and individual preferences. More evidence is needed to determine how CGM may impact pregnancy outcomes in gestational diabetes, though some recent trials suggest CGM can improve glycemic management in GDM and many individuals with GDM prefer CGM.[28–30] (E)
- Use capillary blood glucose testing for all women with GDM, and provide education to support consistent use. (A)

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Clinic Conversations

- **Listen and validate:** Managing diabetes is already a complex, full-time job, but narrower TIR targets, added pressure, and unknown factors of pregnancy can increase distress. Checking in on someone's overall wellbeing can set the tone for more productive, collaborative problem-solving.
- **CGM data is for the user and care team:** Reviewing data and discussing patterns together can support self-management and improve the overall care plan.
- **Monitor for data overwhelm:** While CGM and AID can ease some of the demand diabetes and pregnancy place on time and mental energy, wearing devices, getting alarms, and 24/7 data can sometimes be overwhelming. A little empathy (and resources) can go a long way!
- **Individualize:** Adjust glucose goals and technology recommendations according to access, support, preferences, and other personal factors. Particularly with AID system adjustments, provide and/or refer to educational resources and other support, intensifying as needed to ensure confidence in using the device effectively.
- **Troubleshoot together:** Share other strategies to help AID systems work as well as possible, such as:
  - Deliver meal-time insulin boluses 10–15 minutes before eating and up to 30 minutes prior in late pregnancy.
  - Some clinicians recommend changing AID system infusion sets more often, or trying infusion sets with different cannula angles to help with insulin absorption and comfort as needs change throughout pregnancy.

Practical Pearls

- **Changing needs:** After first trimester, insulin needs change frequently as insulin resistance increases and insulin absorption slows (or insulin secretion is reduced in more advanced type 2 diabetes). Frequent treatment adjustments may be necessary.
- **Remote monitoring:** CGM and AID data can be shared with the clinic and accessed remotely. This can allow the health team to answer questions and make adjustments in between visits, without the burden of an additional in-person appointment.
- **A1C inconsistencies:** A1C results may appear lower during pregnancy, regardless of glycemia. CGM metrics are valuable to contextualize A1C and provide additional insight into glucose levels. Check out this guide to learn more.
- **Backup plans:** Even when using CGM and AID, ensure individuals have access to a capillary glucose meter and test strips, and a backup form of insulin delivery if applicable. Discuss when to use these alternatives.
- **DKA prevention:** Provide ketone monitoring equipment and educate re: risk factors and symptoms to monitor.

More Resources

- **CGM Guide** - to discuss available options
- **AGP Report Guide** - quick guide to interpreting CGM data
- **Healthcare Professional Toolkit** - more tips and tricks on integrating CGM into your practice
- **CGM billing codes**
- **Remote CGM data interpretation billing codes**
- **DME v. Pharmacy Benefits Guide** - for help accessing diabetes tech

Find all of this and more at **timeinrange.org**!

References

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