Thank you for allowing me to testify today in support of House Bill 3380 on the advantages of using continuous glucose monitoring (CGM) devices to treat patients with diabetes, with the intent to gain universal approval of CGM devices in patients with either type 1 or type 2 diabetes. I am an assistant professor of medicine and board certified endocrinologist and diabetologist at Oregon Heath and Science University with specific clinical experience and expertise in type 1 diabetes management in adults, and I also have clinical research experience and expertise with diabetes technology, including glucose meters, insulin pens, insulin pumps, continuous glucose monitors, and others.

The evidence is clear in medical literature that the use of CGM devices improves glycemic control and lowers hemoglobin A1c levels in individuals with diabetes regardless of other factors, such as age, sex, type of diabetes, whether or not an insulin pump or other specialized delivery device, is used. The American Diabetes Association has included the recommendation of CGM use in adults diagnosed with diabetes as level A, meaning that there is a strong body of medical evidence behind the recommendation (refer to ADA Standards of Care [SoC] 2023, recommendations 7.11 and 7.12 for use of real time CGM devices in adults using insulin, either basal only or multiple doses per day), and level B for younger individuals (refer to ADA SoC 2023 recommendation 7.13).

Type 2 diabetes is much more common that type 1 diabetes (~85% versus ~10% of all patients with diabetes), and so many of our patients continue to have poorly controlled diabetes without access to CGM devices that could improve their level of control considerably. Although anecdotal by definition, my experience in the clinic has been nothing less than positive and encouraging every time one of my patients reports to me how impressed they are with their level of control after starting CGM device. Conversely, when patients lose their coverage for CGM device, being forced to abandon its use due to high monthly costs, it is clear that their satisfaction with control of diabetes declines, and their hemoglobin A1c increases.

Poorly controlled diabetes is the most common reason, in the United States right now, for sudden blindness, for dialysis to manage chronic kidney disease, and for non-traumatic amputations. It is a significant risk factor for all forms of cardiovascular disease, one of the most common causes of mortality in the US.

Taking fingersticks to measure blood glucose is like taking photographs of an activity and then asking someone who hasn't seen the activity to guess what is going on.

As a prototype of improved control of glucose after starting CGM device, a patient of mine from my clinic just today, who was having a lot of difficulty with control over the past 3 years with a hemoglobin A1c of over 10% or an average glucose of over 240 mg/dl throughout that time, started CGM only 3 weeks ago, and their 14-day average today from his sensor was 150 mg/dl.

Finally, diabetes in pregnancy is a known and significant cause of morbidity and mortality for both mother and child, and ensuring much tighter levels of control than outside of pregnancy, as recommended by the ADA as well, is much easier to achieve with the use of CGM devices.

I urge the committee to please consider this testimony as strong recommendation for approval of CGM devices for all patients with diabetes of any diagnosis, especially once initiating insulin therapy at any level.

Thank you.