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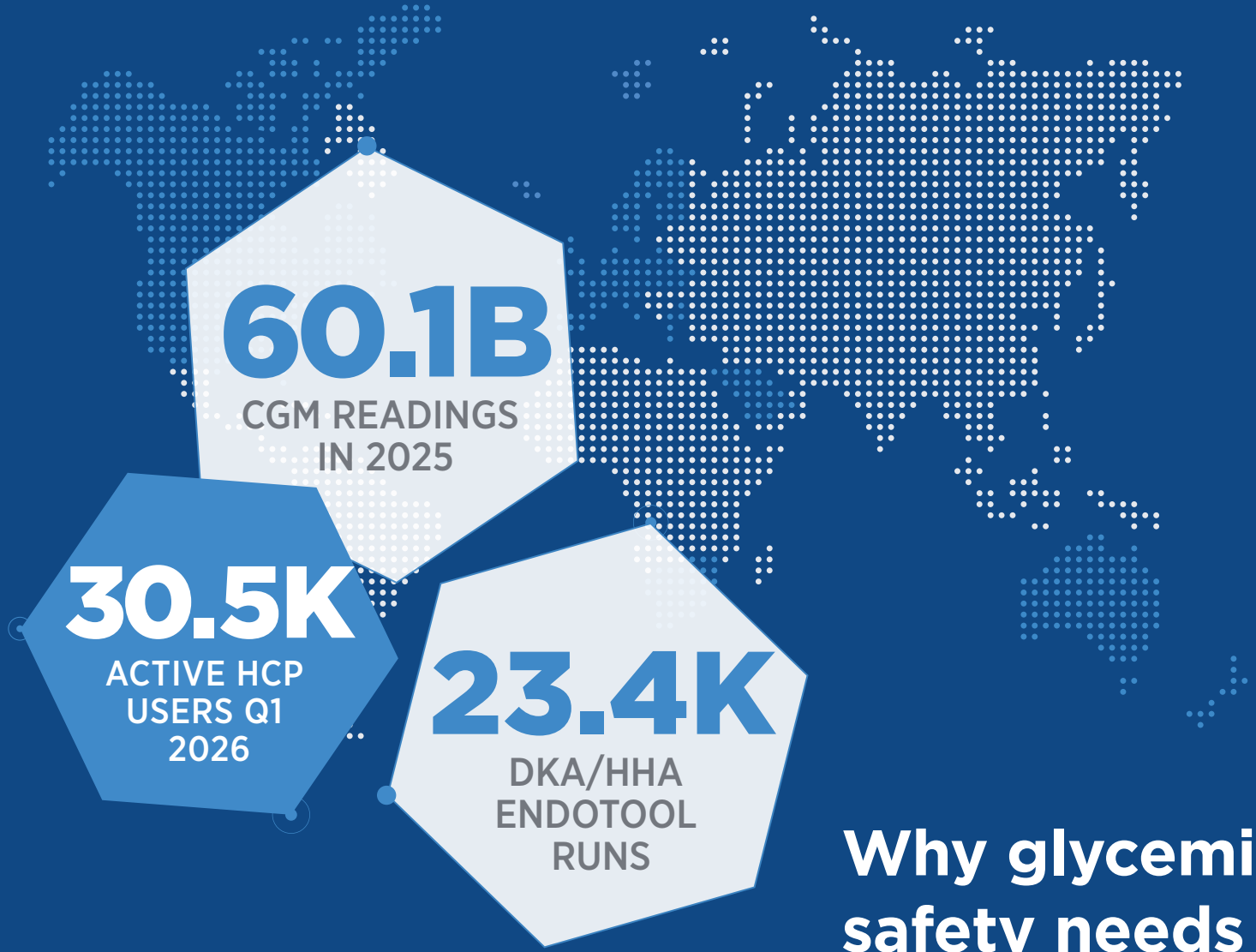
2026 GLOBAL DIABETES REPORT

From Hospital to Home: Glycemic Management Across the Continuum



Why glycemic safety needs a continuum lens

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Why glycemic safety needs a continuum lens

Diabetes care has always required clinical judgment, persistence, and partnership. But the work of diabetes management is changing. Today, clinicians, patients, device partners, hospitals, and health systems are navigating more data than ever before — continuous glucose monitoring readings, insulin delivery data, device uploads, remote monitoring signals, inpatient glucose trends, medication context, and quality measures. The opportunity is enormous and so is the burden.

For data to improve diabetes care, it cannot simply be available. It has to become understandable, clinically relevant, and usable in the moments when care teams need to make decisions. It has to help clinicians see which risks are emerging, which patients may need attention, and which patterns might otherwise remain hidden inside averages or isolated encounters.

That is the focus of this year's Glooko Global Diabetes Report.

The scale of connected diabetes data has reached a new threshold. By 2025, more than 60 billion CGM readings flowed through the Glooko platform, supported by more than 1 million active patients, 30,500 clinicians, 9,000 clinics, and a global footprint across 1,082 geographic locations. This scale is not included in the report as background context. It is the foundation for a different kind of insight: the ability to see change across populations, identify risk patterns that no single clinic could see alone, and surface cohorts that may benefit from more focused review.

This year's data also shows how quickly diabetes care is evolving. Device use is shifting across geographies and across diabetes types. Automated insulin delivery (AID) adoption has grown rapidly, including among people with Type 2 diabetes — a population that has historically been less visible in advanced diabetes technology research. These changes matter because the connected population of today is not the same as the connected population of five years ago. As devices, workflows, and patient behaviors evolve, diabetes data must evolve from static measurement to dynamic population intelligence.

The report also reinforces that summary metrics do not always tell the whole story. Time in Range (TIR), Glucose Management Indicator (GMI), Time Below Range (TBR), and Time Above Range (TAR) remain important, but they can flatten the timing, recurrence, and severity of risk. Two patients may appear similar by standard metrics and still face very different safety concerns. One may have repeated overnight lows. Another may carry persistent daytime hyperglycemia. A third may look near target, but still face clinically meaningful overnight hypoglycemia risk.

That is why this report examines not only what happened, but when it happened and who may be most at risk. The overnight hypoglycemia model is one of the clearest examples. In the updated analysis, the highest-risk group appeared near target by familiar measures, yet had substantially more overnight hypoglycemia exposure; the model was validated across 586,549 patient weeks and showed a 2.79x lift in identifying observed overnight hypoglycemia compared with baseline selection.

This is the practical value of connected data at scale. It can help clinicians and care teams move from broad review to more focused action. It can show that low overnight hypoglycemia risk does

Note: Real-world data and summaries presented herein are intended for educational purposes.

not necessarily mean low overall burden, and that near-target control does not always mean low safety risk. It can help separate overnight lows, daytime highs, variability, and composite glycemic risk so care teams can ask better questions and focus their limited time more effectively.

This year's report also extends the glycemic safety conversation into the hospital. Inpatient glycemic management is highly individualized, especially for patients with diabetic ketoacidosis (DKA) or Hyperglycemic Hyperosmolar State (HHS), renal impairment, steroid exposure, acute illness, changing nutrition status, or complex insulin needs. EndoTool data offers a complementary view of this inpatient safety layer, showing how patient-specific factors shape glycemic management during acute care. Together, clinic-level Glooko insights and inpatient EndoTool insights point toward a broader continuum-of-care opportunity: not one dataset, one dashboard, or one encounter, but a more connected understanding of glycemic safety across the hospital, clinic, and home.

We are careful not to overstate what is connected today. The outpatient and inpatient data views in this report are complementary, not interchangeable. But taken together, they show where diabetes care is headed. The future is not simply more data. It is better signal clarity. It is population-level visibility paired with patient-level action. It is workflow-driven care that helps reduce cognitive burden, support safer decisions, and make risk easier to see before it becomes harmful.

For frontline clinicians, we hope this report validates both the complexity of diabetes care and the need for tools that make data more actionable. For device partners, we hope it shows the value of connected ecosystems that can translate device data into population insight. For hospitals and health systems, we hope it illustrates why glycemic safety should be treated as a cross-setting, workflow-driven priority.

The insights in this report are real-world data summaries intended for education and discussion. But the purpose behind them is practical: to help the diabetes community better understand where risk concentrates, how care is changing, and how connected data can support safer, more focused diabetes and glycemic management at scale.

Mark Clements, M.D., Ph.D.
Chief Medical and Strategy Officer

Trisha Martinez, M.B.A., B.S.N., R.N.
Senior Clinical Transformation Director

Population health is moving from measurement to targeted action

The operational challenge is not whether data exists - it is who needs attention first.

CORE INSIGHT

Connected devices, remote uploads, and cloud-synced data have changed the scale of diabetes management. For many teams, the challenge is no longer a lack of glucose data. The challenge is turning that signal into focused, workflow-ready action.

Population health teams need to stratify cohorts, recognize where risk is concentrating, and decide when to intervene between visits. That requires a richer safety lens than summary metrics alone can provide.

WHAT POPULATION HEALTH TEAMS NEED NOW

- A population-level view of risk, not only individual downloads.
- Prioritized lists that separate urgent risk, improving risk, and lower-risk noise.
- Multi-metric context: TIR, TBR, TAR, GMI, CV, GRI, and time-of-day patterns.
- Remote-monitoring workflows that help teams act between scheduled visits.
- A credible quality and outcomes frame that ties outpatient and inpatient safety together.

Scale makes glycemic safety measurable

Platform-scale data creates a population-level view no single clinic could see alone.

60.1B
CGM READINGS IN 2025

1M+
ACTIVE USERS

CORE INSIGHTS

In 2020, the platform captured roughly 4.0B CGM readings. By 2025, that signal had grown to 60.1B readings - a 15x increase in five years and +1,407% growth versus 2020.

The same scale exists on both sides of the care relationship: patients syncing devices and clinicians reviewing data. Currently, Glooko (including GlookoXT) has 1M+ active users, 9000+ clinics, 1,082 geographic locations across six continents, and 30,504 active healthcare professionals..

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Monitoring change: the technology transition

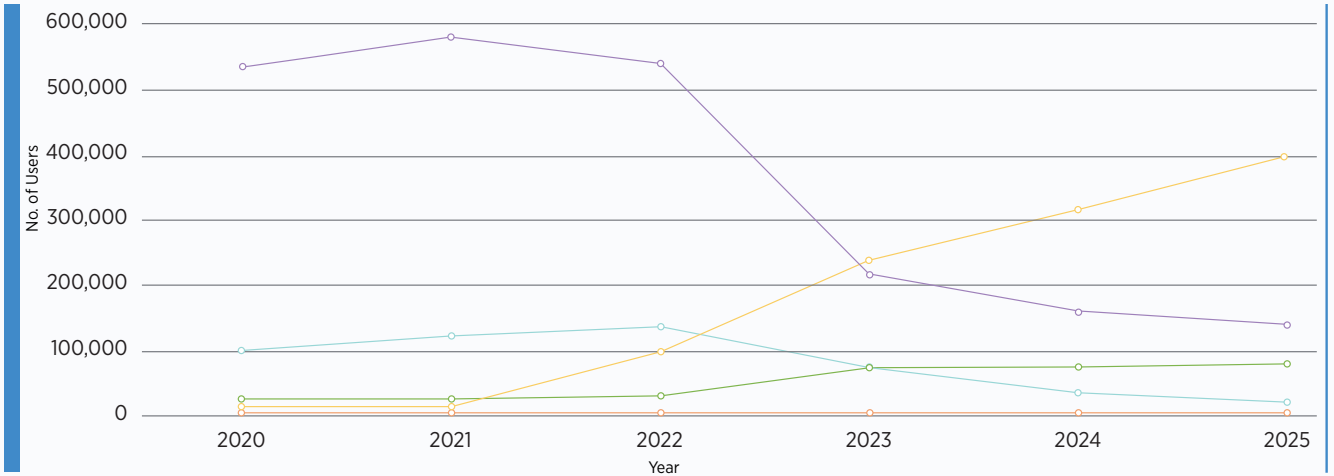
Large longitudinal datasets can detect population-level technology shifts.

CORE INSIGHTS

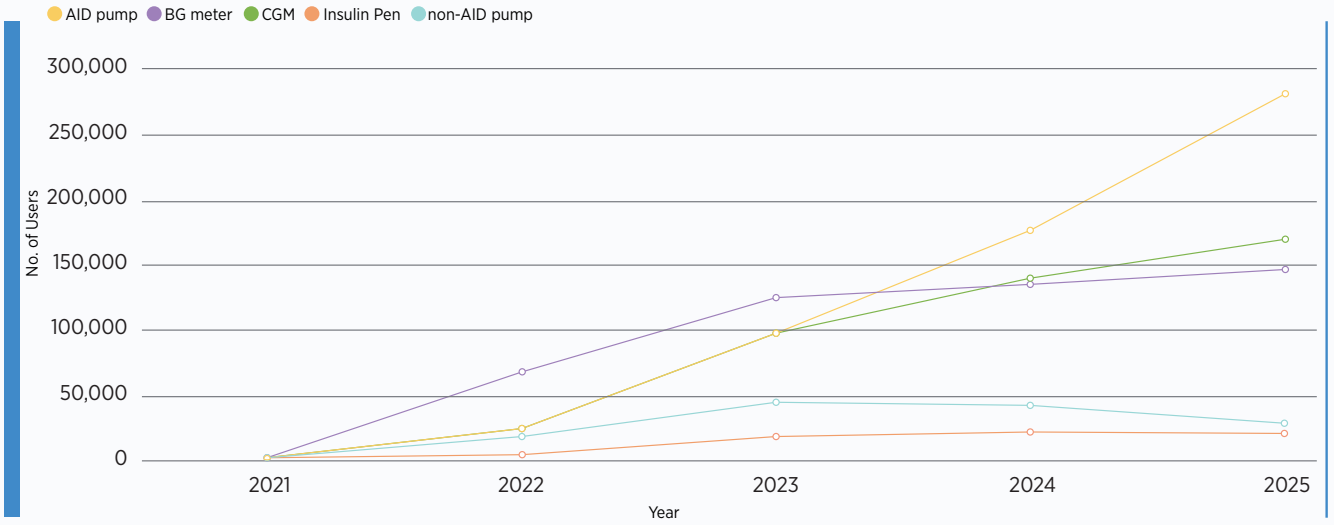
The device usage charts tell a change-detection story: the population using Glooko in 2025 is fundamentally different from the population using it in 2020.

In North America, blood glucose meters declined sharply while AID/pump usage rose to more than 395,000 users by 2025.

In EMEA, AID adoption rose to more than 279,000 users in 2025, while CGM-only users grew to nearly 168,000.



North America Device Usage Trend



EMEA Device Usage Trend

Surfacing cohorts: the Type 2 AID signal

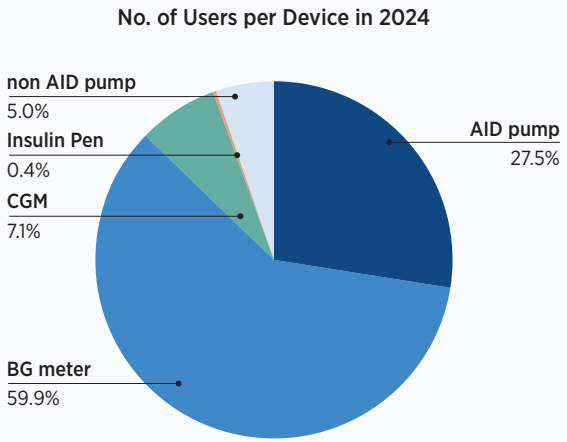
Scale turns aggregate change into cohort-level questions.

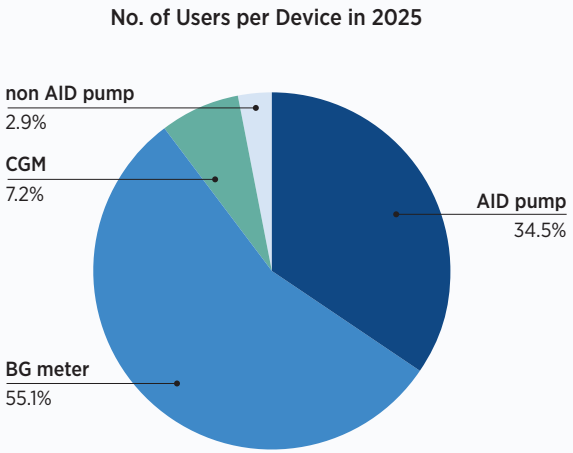
CORE INSIGHTS

Scale also makes it possible to zoom in. The aggregate trend is compelling; the cohort-level insight is where the clinical value lives.

Between 2024 and 2025, AID adoption among Type 2 users in North America grew from approximately 27% to 35% of the device mix - an 8 percentage-point shift in a single year. At the same time, BG meter share declined.

This cohort lens creates the next clinical question: what are the outcomes for Type 2 users who make this transition, and are there sub-cohorts that are moving faster or being left behind?





Where safety risk concentrates in the real world

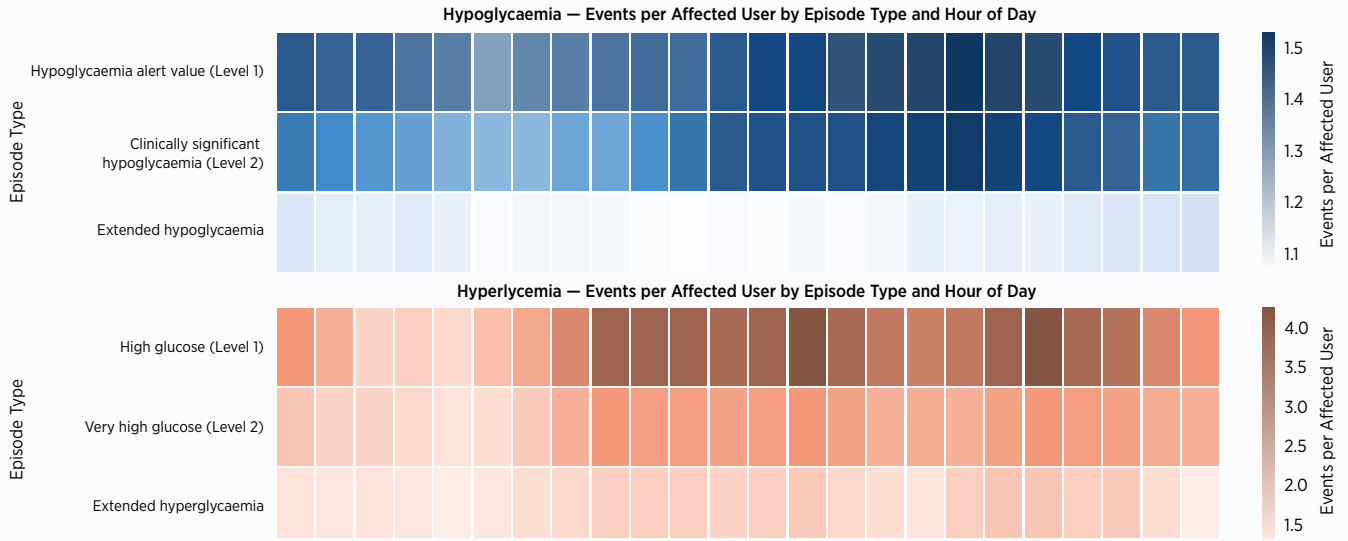
Time-of-day patterns help move the story from aggregate metrics to targeted review.

CORE INSIGHTS

Traditional CGM metrics summarize outcomes, but they can flatten the daily pattern of risk. TIR, GMI, TBR, and TAR show how much risk occurred; they do not always show when risk concentrates or whether it repeats.

At platform scale, Glooko can examine glycemic events by hour of day and event type. Current data shows that hypoglycemia and hyperglycemia follow different daily patterns, pointing to different clinical questions and different opportunities for intervention.

Glooko is always searching for new opportunities for data-driven features on the platform. We have evaluated the feasibility of forecasting hypoglycemia. This is a model we generated internally to demonstrate what this could look like.



Measuring risk, not just control

TIR remains important, but safety-focused population management needs a richer lens.

CORE INSIGHTS

Time in Range (TIR) is an essential starting point, but it cannot fully answer the safety question. Two people or cohorts can have similar TIR while carrying different burdens of overnight lows, daytime highs, glucose variability, or composite glycemic risk.

The goal is not to replace TIR; it is to add the safety context that helps care teams prioritize review.

Measuring Risk, not just control
TIR remains important, but safety-focused population management needs a richer lens

Same TIR. Different event-context fingerprints.

In range (70-180) · Overnight lows · Post-meal highs · Low after High (rebound)

Event context reveals when events happen, what type they are, and what sequesnces they follow — turning a single number into a safety profile.

What context adds:
Few event-context signals; lower priority for safety review

What context adds:
20% of hypo events cluster overnight — where TIR alone makes patients look controlled.

What context adds:
42% of pediatric hypos are lows following a preceeding high — a rebound sequence, not isolated excursions.

Illustrative patient patterns derived from implemented event-context classification. Quantified cohort results on following pages.
Key finding: 42% of pediatric hypos follow a preceeding high (Low after High context). D10 (highest risk decile) has TIR 68% vs D1 (lowest risk) TIR 54% — TIR points the wrong direction for safety.

From surveillance to prioritization

Predictive hypoglycemia risk can surface patients who look controlled but are unsafe overnight.

Total users analyzed: 74,059 (Original Feb. 2026: 65,969)
Delta: +8,090

D10 (HIGHEST RISK) vs D1 (LOWEST RISK) — KEY METRICS

Metric	D10	D1	Ratio
Risk score	0.60	0.07	8.7x
Mean glucose (mg/dL)	151.66	189.25	0.8x
GMI (%)	6.94	7.84	0.9x
CV (%)	37.23	23.08	1.6x
TIR 70-180 (%)	68.48	53.79	1.3x
Overnight TBR <70 (%)	5.9045	0.0752	78.5x
% Readings <70 mg/dL	5.49	0.10	55.8x
% Readings <54 mg/dL	1.57	0.02	81.9x
CGM active (%)	95.25	98.60	1.0x

Glooko model-ranked cohorts: familiar metrics vs hidden overnight risk

Highest predicted-risk cohort looks better by GM/TIR, but carries much higher overnight low exposure.

	Metric	Model bottom decile lowest predicted overnight risk	Model top decile highest predicted overnight risk	What the table shows
MODEL	Predicted overnight hypo risk score	0.07	0.60	8.7x Higher model score
CONTROL	GMI	7.84%	6.94%	High-risk cohort appears closer to target
CONTROL	Time in Range 70-180	53.79%	68.48%	High-risk cohort appears better controlled
SAFETY	Glucose variability/CV	23.08%	37.23%	High-risk cohort exceeds common 36% stability target
SAFETY	Overnight time <70	0.075%	5.90%	78.5x Higher overnight low exposure
SAFETY	Readings <54	0.02%	1.57%	81.9 Higher serious-low exposure

TAKEAWAY: The model separates "looks controlled" from "is safe overnight" — turning CGM data into a prioritization signal for review.

CORE INSIGHTS

GMI and TIR are important, but they do not fully capture overnight hypoglycemia risk. Glooko's overnight hypoglycemia model adds a safety lens by ranking users based on their likelihood of near-term overnight lows.

Recent CGM research[1], including the Glycemia Risk Index (GRI), reflects a shift from control-only metrics toward risk-based interpretation. Glooko's analysis builds on this direction by surfacing patients who look controlled by GMI and TIR, but remain at elevated risk for overnight hypoglycemia.

Near-target can still be unsafe: highest-risk D10 had GMI 6.94% and TIR 68.48%, but 5.90% of overnight time below 70 mg/dL versus 0.08% in D1.

The safety signal is driven by variability and lows: D10 had CV 37.23% versus 23.08%, and 81.9x more readings below 54 mg/dL.

The model creates prioritization: D10 had a 60.8% observed hypoglycemia rate versus a 21.8% baseline rate, a 2.79x lift over random selection.

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Risk profiles are not one-dimensional

Different cohorts carry different kinds of burden: lows, highs, variability, and composite risk.

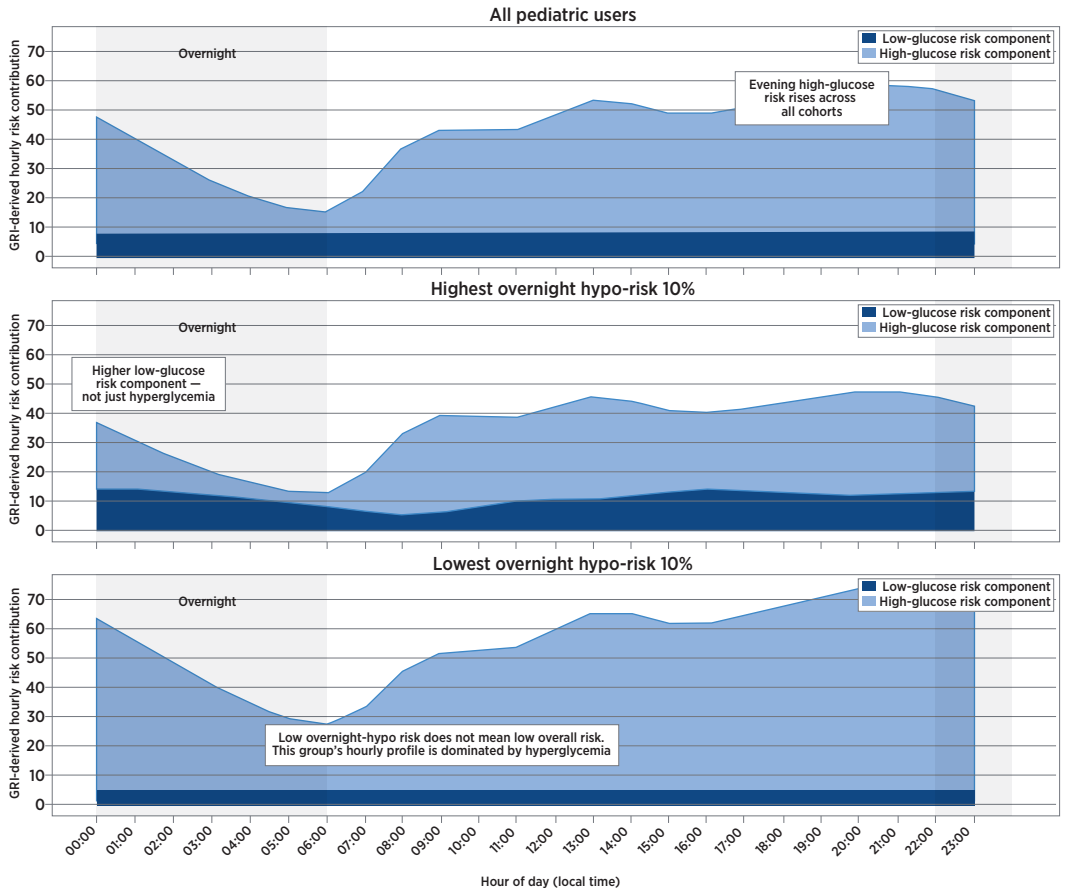
CORE INSIGHTS

Once patients are stratified by overnight risk, their 24-hour profiles do not look the same. The clinical question changes depending on whether the burden is overnight lows, daytime or evening highs, variability, or overall glycemic risk.

These figures show that low overnight-hypoglycemia risk does not mean low total burden, and near-target control does not always mean low safety risk.

24-Hour glycemic risk profile: pediatric users

A 24-hour risk profile separates low-glucose burden, showing when review may need to focus.



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What improves safety at scale in outpatient care

The differentiator is workflow-driven action, not dashboards alone.

82%
NAM PATIENTS WITH DATA VIEWED IN PAST YEAR

13 pts
TIR SPREAD ACROSS YOUNG ADULT TID REGIONS

CORE INSIGHTS

Connected diabetes management has reached meaningful scale. The infrastructure for continuous, remote oversight is already embedded in how care is delivered. The question is whether care workflows are built to act on it.

Across a population with universal device connectivity and cloud-synced data, regional outcome variance remains substantial.

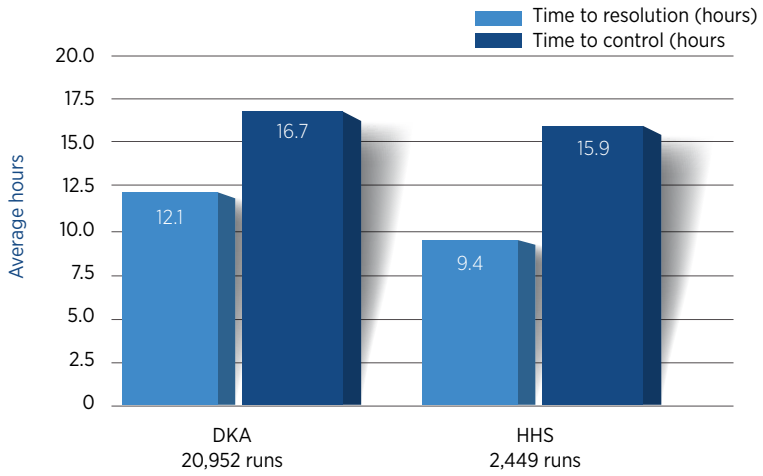
TAKEAWAY | The differentiator is turning connected data into prioritized action across patients, cohorts, clinics, and regions.

EndoTool patient-complexity outcomes panel

WHAT IS INPATIENT INSULIN DOSING?

Inpatient insulin dosing is the process of determining safe and effective insulin recommendations for hospitalized patients whose needs may change rapidly. EndoTool applies a patient-specific algorithm using up to 11 clinical factors—such as renal function, steroid use, nutrition, diabetes type, and mode of therapy—to support more individualized dosing decisions.

EndoTool acute complication outcomes - 2025



EndoTooDKA/HHS outcomes from 2025 EndoTool Outcomes spreadsheet.

Inpatient glycemic safety is the acute-care counterpart to Glooko's outpatient population health story. Outside the hospital, connected data can help identify risk earlier and prioritize intervention. Inside the hospital, that risk becomes more immediate, more complex, and more dynamic.

EndoTool is the inpatient expression of this safety strategy. It supports individualized insulin dosing during high-complexity episodes, helping care teams respond as glucose, nutrition, renal function, steroid exposure, and clinical status change. This is especially important for patients with acute complications such as DKA or HHS, where timely stabilization and avoidance of severe excursions are central goals.

The 2025 EndoTool outcomes data make this safety story tangible. Across 20,952 DKA runs, average time to resolution was 12.1 hours and average time to control was 16.7 hours. Across 2,449 HHS runs, average time to resolution was 9.4 hours and average time to control was 15.9 hours. These metrics show how EndoTool supports inpatient teams during some of the most complex glycemic events they manage.

The data also reinforce why patient-specific dosing matters. Renal impairment, steroid use, pregnancy, and diabetes type can all affect insulin needs. For example, steroid-associated runs had longer average time on drip than non-steroid runs, while severe hypoglycemia remained infrequent in both groups. This does not prove steroids alone caused the difference, but it reflects a familiar inpatient challenge: glycemic risk can change quickly as treatment changes.

EndoTool's role in this report is clear: it is the inpatient safety layer. It helps hospitals manage acute glycemic instability, support individualized dosing, reduce variation, and stabilize patients safely when clinical conditions are changing quickly.

EndoTool: individualized inpatient glycemic management

EndoTool is the inpatient expression of glycemic safety, including acute complication management and patient-specific dosing complexity.

DID YOU KNOW?

CMS hospital harm eCQMs are increasing the visibility of inpatient glycemic safety. For the 2026 reporting period, Hospital Harm — Severe Hyperglycemia and Hospital Harm — Severe Hypoglycemia are mandatory eCQMs for reporting, according to The Joint Commission's 2026 reporting update. Patients must remain hospitalized for a minimum of 24 hours before CMS can count the event within the metric.

Patient-specific dosing factors: steroid exposure example

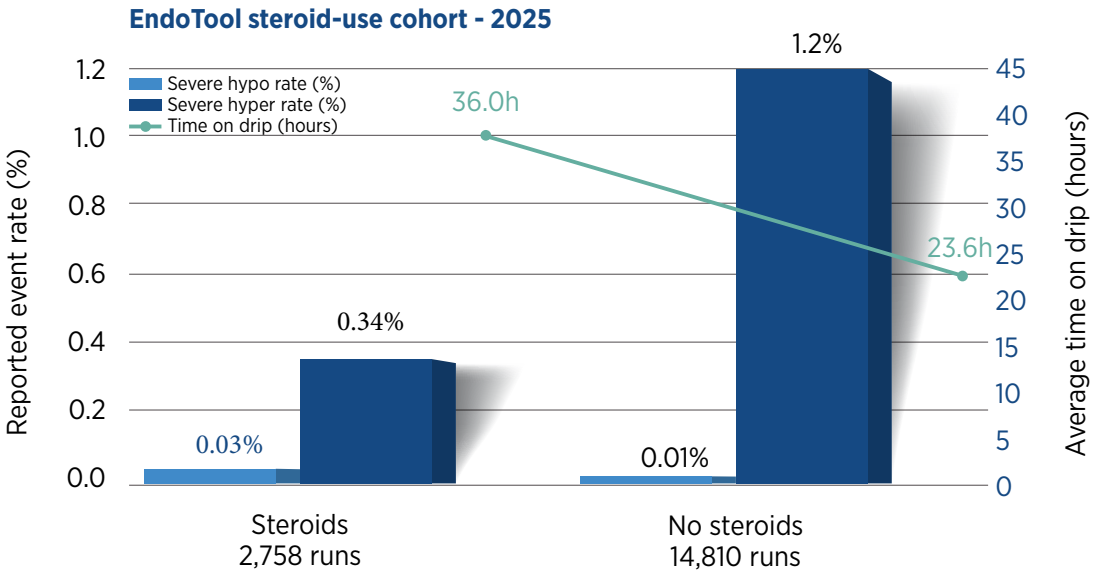
CORE INSIGHTS

Steroid exposure is a clinically meaningful complexity factor in inpatient glycemic management. Steroid exposure adds dosing complexity because insulin needs can change as treatment changes.

In the 2025 EndoTool cohort, steroid-associated runs had longer average time on drip than non-steroid runs (**36.0h vs. 23.6h**), while severe hypoglycemia remained infrequent in both groups. This is descriptive, not causal, but it reinforces the need for individualized inpatient insulin dosing.

"EndoTool supports individualized inpatient dosing across patient-specific complexity factors such as renal function, steroid exposure, and diagnosis."

Dr. Paul Chidester



Steroid-use cohort descriptive chart from 2025 EndoTool Outcomes spreadsheet.

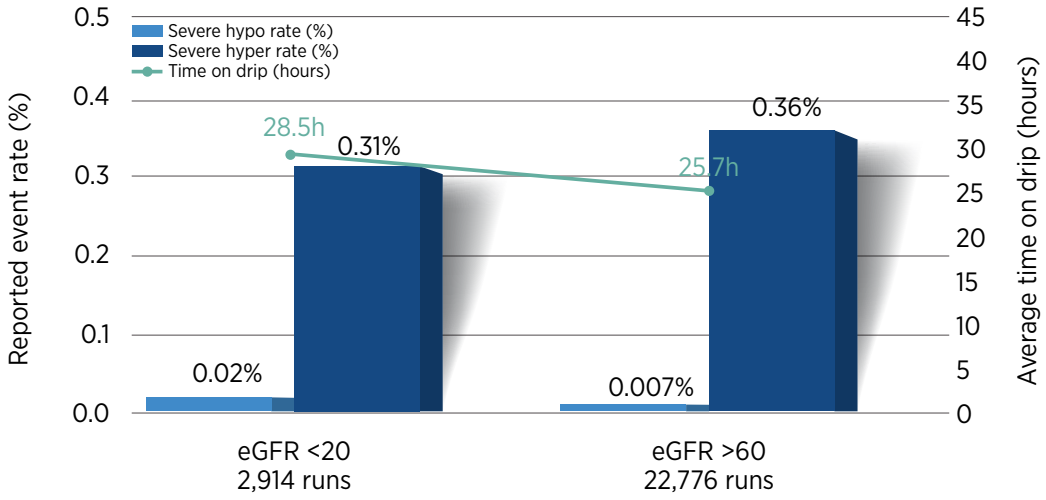
Patient-specific dosing factors: eGFR example

CORE INSIGHTS

Renal function adds an important layer of inpatient dosing complexity. In this 2025 EndoTool cohort, patients with eGFR <20 and eGFR >60 both had very low rates of severe hypoglycemia and similar rates of severe hyperglycemia. The lower-eGFR cohort had a somewhat longer average time on drip, reinforcing kidney function as patient-specific context rather than a simple risk label.

Patient-specific dosing factors: eGFR example

EndoTool eGFR cohort - 2025



0.02% severe hypo, eGFR <20

0.31% severe hypo, eGFR <20

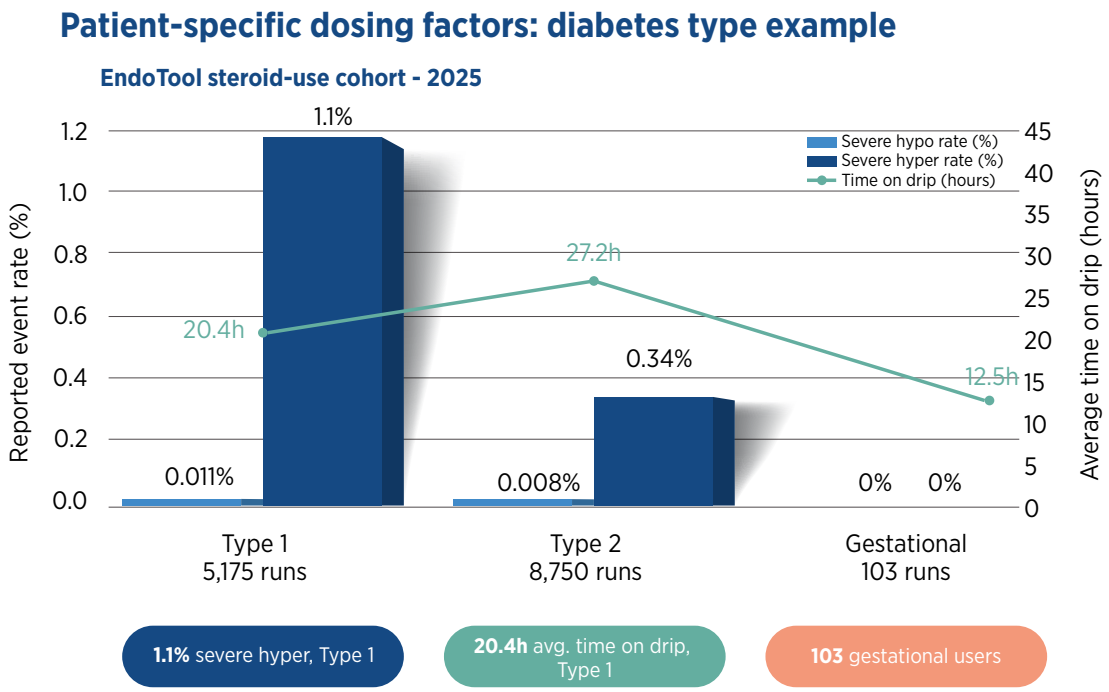
28.5 5h avg. time on drip, eGFR <20

Context: EndoTool supports individualized inpatient dosing when clinical factors such as renal function, steroid exposure, nutrition, diabetes type, and mode of therapy can change insulin needs.

Patient-specific dosing factors: diabetes type example

CORE INSIGHTS

Diabetes type at model start helps contextualize the kind of inpatient glycemic complexity care teams are managing. Type 1 runs showed the highest reported severe hyperglycemia rate but shorter average time on drip than Type 2. Gestational runs had no recorded severe events and the shortest time on drip, but the cohort was small, so the safest interpretation is descriptive support for individualized dosing across diagnosis-specific profiles.



Steroid-use cohort descriptive chart from 2025 EndoTool Outcomes spreadsheet.

Connecting inpatient stabilization and outpatient monitoring

CORE INSIGHTS

Glycemic safety does not stop at discharge, but the hospital-to-home story should be framed carefully. Inpatient insulin management is not a linear pathway. Depending on clinical presentation and severity, patients may be managed with subcutaneous (SubQ) insulin alone, require IV insulin with subsequent transition to SubQ therapy, or initially start on SubQ insulin and later escalate to IV insulin as clinical needs evolve.

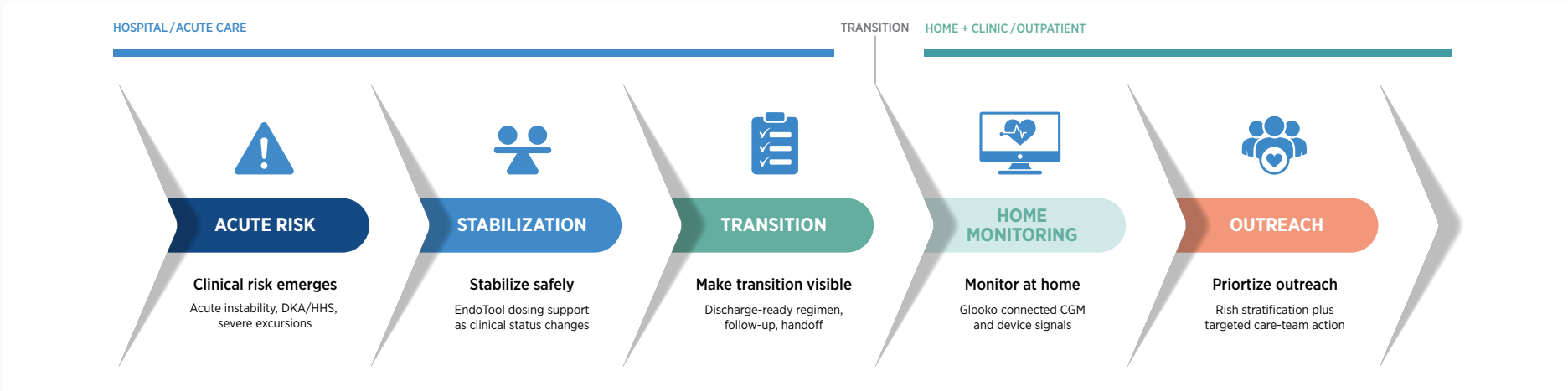
The stronger continuum story is about complementary safety objectives. In the hospital, the priority is acute stabilization: bringing glucose into control, adjusting dosing as clinical status changes, and reducing severe excursions. After discharge and between visits, the priority becomes sustained visibility: identifying hypoglycemia, hyperglycemia, variability, or worsening trends before they become emergencies.

Together, EndoTool and Glooko point toward a broader glycemic safety model. EndoTool supports safer inpatient stabilization when clinical risk is changing quickly. Glooko supports outpatient visibility and prioritization when risk is distributed across a population. The connection is not a claim of fully integrated patient-level data today; it is a credible vision for how glycemic safety should extend across hospital, clinic, remote monitoring, and home.

That is the promise of a hospital-to-home approach: the right data signal at the right moment. Stabilize risk in the hospital, maintain visibility after discharge, and help care teams act earlier when connected data shows risk returning.

HOSPITAL-TO-HOME GLYCEMIC SAFETY MODEL

A conceptual continuum for linking acute inpatient stabilization to sustained outpatient visibility and earlier outreach.



Richer population stratification

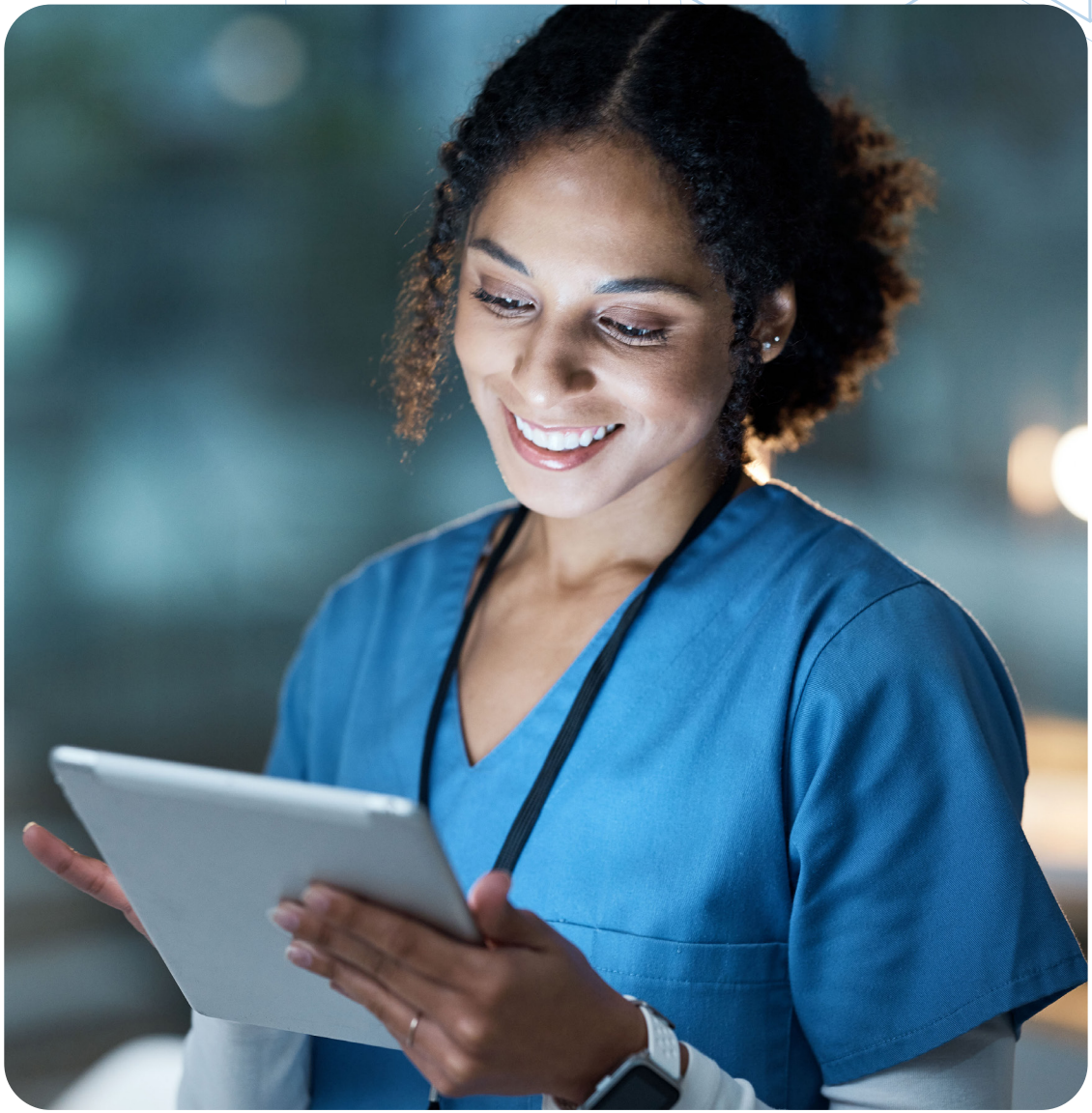
CLOSING

This report shows that connected diabetes data has reached a new stage. The signal is large enough to reveal population-level change, daily risk patterns, hidden overnight safety concerns, cohort-specific differences, and opportunities for action between visits.

But the value of connected data is not the data itself. The value is how it makes it easier for care teams to see risks and take action.

For clinicians, the opportunity is greater signal clarity: understanding which patients may need attention, when risk is emerging, and which patterns may be hidden behind familiar averages. For technology leaders, it is a reminder that connected ecosystems can generate insight far beyond individual device use. For hospitals and health systems, it is a call to treat glycemic safety as a workflow-driven priority across the hospital, clinic, and home.

The next chapter of diabetes care will not be defined by more data alone. It will be defined by connected intelligence that helps reduce burden, focus clinical attention, and support safer decisions at scale.



The insights in this report are just some examples of what the Glooko platform is capable of. Learn more about Glooko's full data capabilities and insights:

ABOUT GLOOKO

Glooko is a global digital health company focused on helping clinicians address the growing challenges of glycemic safety and diabetes management across the care continuum. Glooko is uniquely positioned to be the enterprise partner of choice for healthcare providers seeking to reduce glycemic risk, improve safety, and support overburdened clinical teams with coordinated expertise across both outpatient and inpatient care settings.

Our connected care solutions portfolio includes the outpatient Glooko diabetes management platform, Glooko Mobile App for people with diabetes, inpatient EndoTool Glucose Management System, and the Glooko XT remote patient monitoring platform in France.

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