

Glycemic Management of Type 1 Diabetes

Key Messages for Healthcare Providers

Glycemic Targets Should Be Individualized

Glycemic targets are aligned across the lifespan, with a glycated hemoglobin (A1C) goal of <7.0%. Targets should be individualized using a person- and family-centred approach, and shared decision-making is essential when setting goals. For those using continuous glucose monitoring (CGM), additional targets are provided.

Person- and family-centred shared decision-making

CGM targets for glycemic management for most people with type 1 diabetes

TBR (time below range)		TIR (time in range)	TAR (time above range)	
<3.0 mmol/L	<3.9 mmol/L	3.9–10.0 mmol/L	>10.0 mmol/L	>13.9 mmol/L
1.0%	4.0%	70% [§]	25%	5%

[§] Corresponds with an A1C of approximately 7%. Every absolute 10% change in %TIR correlates with 0.5%–0.8% change in A1C.

AID Systems Are Preferred

Automated insulin delivery (AID) systems (pump + CGM + algorithm) are the preferred treatment method to optimize glycemia and person-reported outcomes. Accurate carbohydrate counting is not a requirement. Regularly review infusion site management, glycemic management, pump function, ketone troubleshooting, and sick-day management to support optimal AID use.



When AID Not Used, Use CGM With BBI

When AID is not chosen or possible, CGM should be used in combination with basal-bolus injection (BBI) therapy.

Use long-acting basal analogues over NPH to reduce hypoglycemia and improve glycemic outcomes.



Adjunctive Therapies When Needed

Adjunctive therapies may be appropriate to help with outcomes like weight. Shared decision-making should be employed to balance benefits and risks.

Always Be Prepared for Hypoglycemia

Individuals with type 1 diabetes should always have access to fast-acting glucose; doses to correct hypoglycemia vary by age and insulin delivery. Glucagon should be prescribed for everyone with type 1 diabetes.

