CLOSER LOOK

MEMORANDUM

Interview with Glooko's leadership team on its acquisition of Monarch Medical and the integration of inpatient insulin dosing algorithm EndoTool – November 4, 2025

Our team met with Glooko leadership shortly after the company announced the acquisition of Monarch Medical Technologies, the developer of the EndoTool Glucose Management System. Mr. Rich Glenn (President, Connected Care), Mr. Mike Alvarez (CEO), and Dr. Mark Clements (CMO) were eager to share details on the FDA-cleared software that evaluates blood glucose values to recommend patient-specific inpatient insulin doses, as well as Glooko's vision for its eventual integration with Glooko's existing outpatient platform.

EndoTool aims to reduce hypoglycemia risk and standardize outcomes across critical care units with patient-specific dosing recommendations through algorithms that consider insulin sensitivity, nutritional intake, and comorbidities. By pairing EndoTool's dosing algorithms with Glooko's outpatient diabetes device integrations and remote monitoring platform, the company aims to streamline the transition from hospital to home, reduce readmissions, and better align inpatient care with post-discharge management. They shared, "We imagine patients being discharged with a CGM … and a transitional care coordinator having visibility into their data during the gap between discharge and their first follow-up. That allows them to prioritize their time and their resources and treat patients on a personalized basis instead of calling down a list alphabetically. We think that's one of the first use cases hospitals and health systems will adopt."

In tandem with the upcoming CMS' electronic clinical quality measures (eCQMs) aiming to tackle inpatient hypo- and hyperglycemic crises rolling out in the US January 1, 2026, Mr. Glenn, Mr. Alvarez, and Dr. Clements illustrated a clear niche for an integrated inpatient-outpatient dosing algorithm and glycemic management platform.

See more below, including top takeaways and the full conversation.

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Top Takeaways

- **On the strength of EndoTool in diabetes management:** Dr. Clements explained that EndoTool is differentiated in two ways: (i) it has a long history of evidence demonstrating its effectiveness; and (ii) it uses specific algorithms for different populations and settings. Specifically, he highlighted algorithms tailored to IV insulin therapy in critical care units, subcutaneous insulin in non-critical care, and specialized versions for individuals with diabetes and a comorbid renal insufficiency – a level of algorithmic personalization that he "just hasn't seen yet with other algorithms."

- **On Glooko's vision with EndoTool integration:** Mr. Glenn explained that the goal of the Monarch Medical acquisition is the seamless integration of the two offerings, closing the gap between inpatient and outpatient care. Currently, hospitals approach transitional care differently; some rely on pharmacists, others on home health or third-party services. Dr. Clements identified a couple of critical transition points where having both product solutions "under the same roof" really would make a difference.
    - **Admission:** Once admitted, inpatient teams could immediately see what the diabetes self-management of patients already on the Glooko platform looked like in the days (and weeks) leading up to admission.
    - **Insulin dosing.** While EndoTool isn't technically a machine learning algorithm, Dr. Clements emphasized that it is a series of multi-variable statistical algorithms that personalizes insulin dosing for different cohorts of individuals based on an individual's characteristics and health state. With additional information on insulin usage in the 24 hours prior to admission, patients can reach the right dosage with fewer errors than starting from guesswork.
    - **Discharge.** By combining inpatient data with the first few days post-discharge, you could classify risk more efficiently and apply risk-based care protocols. Furthermore, by integrating inpatient and outpatient glycemic data to inform future algorithms and detect emerging risks during hospitalization, it can help clinicians act sooner to prevent deterioration. Mr. Alvarez added that when patients visit their endocrinologist in the weeks following discharge, their provider can review data from before, during, and after hospitalization to create a more informed care plan.
- **On global expansion of the integration:** Mr. Glenn noted that as half of Glooko's users are in Europe and EndoTool is currently approved only in the US, regulatory and market pathways in Europe are already being explored. As the clinical need is the same in both geographies, an international expansion is a "logical next step" supported by Glooko's "large and loyal" European user base.
- **On eCQMs measures:** Mr. Alvarez emphasized the need for integrated inpatient-outpatient systems in the US. With CMS measures for reporting severe hypo- and hyperglycemic events beginning in January 2026, he estimated that only 10-15% of hospitals currently have associated programs in place. Data suggest that Monarch offers a superior algorithm, creating an opportunity to pair Glooko's enterprise presence with Monarch's hospital expertise. With hospital performance rankings publicly available by the end of 2026, he suggested that patient safety and effective insulin dosing tools will be a top priority for hospital CMOs, increasing the attractiveness of an integrated tool like EndoTool.

Interview with Mr. Rich Glenn and Mr. Mike Alvarez

On the Monarch Medical acquisition

Jeremy Alkire: We thoroughly appreciate this opportunity to speak with y'all. I wanted to dive into your incredibly exciting announcement: the acquisition of Monarch Medical Technologies, including its EndoTool for inpatient insulin dosing systems. Importantly, this gives Glooko access to the full continuum of diabetes care, both inside and outside of the hospital. Could tell us more about how EndoTool will be integrated into Glooko's existing platform, and what this integration might look like for providers who are using it?

Mr. Rich Glenn, President of Connected Care: While it's early days, we certainly plan to integrate the two systems over time. It will take some work, however, as we want to ensure that we keep the patient journey and the clinicians treating those patients at the forefront. Eventually, we envision a seamless solution for patients who have been admitted to the hospital, in which if they were already in Glooko, we can make visible to their care team their glycemic data prior to admission to help guide dosing decisions.

Importantly, there should also be a tether for patients between admission and discharge. With this integration, you'd be able to see exactly what has happened after the patient was admitted, and endocrinologists or their primary care physicians in the weeks following could review that data before the patient is seen. That's the end goal as far as the technical integration.

It’s probably a little bit too early to describe exactly what that will look like. But that's one of the first things we're doing. In fact, I was in touch with a customer today to figure out the best way to integrate the two the two platforms that they're currently using.

Mr. Mike Alvarez, CEO: What I would add, Jeremy, is that when we were talking to hospital administrators, critical care nurses, and others, we realized that there's a big problem in the US healthcare system. It sees *seven million* admissions a year, and 30-40% of those go into critical care with a need for insulin. Some of these are diabetes de novo diabetes patients, some develop diabetes while hospitalized, and others – with their bodies under acute stress – require insulin just during their stay. But some end up needing insulin well beyond the hospital, and it’s important is to identify those patients at discharge.

As we know, there's a tsunami of patients that are hitting the shores, and there's this crisis among US caregivers. We don't have enough endocrinologists, nurse practitioners, or diabetes educators. That's where companies like Glooko come in – using our digital health technology to bridge that gap.

I envision a world where a patient is discharged on a Glooko app, maybe with a CGM and a patch pump, or some other technology. And then they wait. You know, the average wait time to see an endocrinologist in the US could be eight to 12 weeks depending on where you live. So, what do you do with that patient? In the perfect scenario, the patient shows up eight or ten weeks later to their endocrinologist with the app, and the endocrinologist can see: “This is how you looked before you went to the hospital, this is your data while in the hospital, and this is what happened during the eight weeks you waited to see me. Based on that, here's the care plan that I want to put together for you.” In the end, that can lead to better patient outcomes, lower costs for the healthcare system, and a more efficient way of delivering care.

On integration awareness among HCPs

Jeremy: You touched on a really important point about the variability in today's healthcare system – not only across inpatient and outpatient care, but across all of the different types of providers that patients with diabetes see. Do you see a need for an awareness campaign among providers about this expanded offering from Glooko and the way it'll be integrated into the healthcare system?

Mr. Alvarez: Not only an awareness campaign with clinicians, but also with the fellows. Some of the great opportunities we see are training the fellows in those programs so that they're aware of the technology as they go out into practice. That's part of the healthcare professional awareness, along with nurse educators, diabetologists, and others.

Then you have patient awareness as well. There are multiple fronts we will be working on. The good news is this combined entity will be the only one in the world that does this. We feel we have a big responsibility to get it right. We just got off a call with the Monarch team where we were discussing exactly this: what is the next step? Over the next few months, we will be putting teams together to figure out the right approach with our customers – who we've already been engaged with, as Rich mentioned – to make sure we get this right, because it is a huge unmet need. Think about it: three million patients get insulin in the hospital each year. How many of those develop diabetes? How many already had diabetes? And what are we doing about it? Right now, we're not really doing anything. So, here's a great opportunity.

On international expansion

Katherine Moon: I completely resonate with your points about unmet needs. It’s so impressive that different iterations of EndoTool have been available in the US for nearly two decades in inpatient care. As Glooko is a global brand, with nearly half of the users outside the US, how are you thinking about international expansion of the offering?

Mr. Glenn: Great question. We are a global company. About half of our patients are from Europe. While EndoTool is only approved in the US today, we’ve already started exploring both the market and regulatory pathways in Europe. In fact, at EASD last week, we had a KOL dinner where this was one of the main topics. The need is global for sure. The problems are very similar, though referral pathways and management approaches vary. You can expect to see us investigate regulatory pathways quickly – it's a logical expansion of our platform in Europe, where we already have such a strong and loyal user base.

On CGM integration and the inpatient/outpatient care transition

Esther Min: It's really exciting to hear about those discussions already happening! We're also very interested in understanding more about how this integration might play a role in ensuring smoother care transitions from hospital to home. Can you share any thoughts on its role in this setting?

Mr. Alvarez: As part of our due diligence, we did a lot of consulting to address those very questions. Rich actually spearheaded that work, so, why don't you share with that with them?

Mr. Glenn: I think that's probably the easiest use case right off the bat, Esther, because the need is clear. We all know therapeutic areas where patients leave the hospital and very frequently end up readmitted, which hurts the patient and creates adverse financial implications. Through a number of discussions with current users, we found that every hospital looks a little different in how they manage transitional care. Sometimes it includes pharmacists prescribing a CGM and monitoring those patients until they see an endocrinologist or a primary care physician. Other times it's managed by home health or third-party services. There are a variety of approaches, but all hospitals recognize it as a problem. We think Glooko can help.

One of the coolest things we've just launched is our population health dashboard. Imagine patients being discharged with a CGM – which CGM companies are actively pursuing – and a transitional care coordinator having visibility into their data during the gap between discharge and their first follow-up. That allows them to prioritize their time and their resources, and treat patients on a personalized basis instead of calling down a list alphabetically. We think that's one of the first use cases hospitals and health systems will adopt.

Esther: I can certainly see how dashboards like this can help physicians triage patients and tailor treatment. Can you speak at all about how it can help with the continuity between inpatient dosing and outpatient self-management?

Mr. Glenn: Along with what Mike explained earlier, when that outpatient physician receives a patient – often a new one for them – our technical integration will allow access to inpatient dosing data. That way, providers can understand how the patient was managed in the hospital. If it's been several weeks, that data may be less relevant, but our aim is to integrate that data flow and arm clinicians or caregivers with as much information as possible to guide decisions.

Kelly Close: It's so cool to hear about this vision! We're assuming clinicians want all that data, but I'm hopeful that's the case to help improve patient outcomes. When you think about patients leaving the hospital, can you talk about that in terms of insulin, as well as SGLT-2 inhibitors or GLP-1 RAs that may come in the future? Will that become part of the platform? And then, could you share any thoughts on the regulatory environment in the EU?

Mr. Alvarez: In a perfect world, a patient would be discharged with an order set of the Glooko app paired with a CGM or an insulin delivery device. Then, as Rich mentioned, a transitional care model would ensure they don't get readmitted. The Glooko app is optimized for population health, so transitional care managers can see patients flagged red, yellow, or green, and focus attention where it's needed most.

More importantly, as that patient generates data before their first follow-up, their provider can see: what did things look like before hospitalization? During? And after discharge? That gives a much clearer picture for building an action plan, which leads to better outcomes and lower costs. If you don't get it right, patients return to the hospital or repeatedly to their physician until things stabilize.

As we all know, diabetes is already such a difficult disease to manage, which is why companies like ours exists. This is just one more arrow in the quiver to support the patient journey across the full continuum of care – something no one has been doing well. So, we see a great opportunity.

Mr. Glenn: On your question about European regulatory pathways, it's probably too early to comment specifically, but we're uniquely qualified to tackle that. We have a very experienced regulatory team working across over 30 countries, with existing expertise that will help us navigate the different geographies.

Mr. Alvarez: And that's important because the EU is not like the US. It's not one regulatory body. Every country has different rules, especially around patient data, privacy, and server location. The good news is we're already there, and we know how to navigate it. Right now, we're working with KOLs to introduce what's being done in the US so that they can help inform us on next steps and country-specific adaptions before we take it through the regulatory process.

On the upcoming eCQM reporting requirements

Esther: Thank you so much for the insights on how the regulatory process works and how you envision EndoTool fitting in. Could you expand on how this acquisition positions Glooko to meet hospital needs? Specifically, we were curious at its role in helping hospitals adapt to CMS quality measures, including the upcoming eCQM reporting requirements for severe hypoglycemia and hyperglycemia?

Mr. Alvarez: That was actually a big driver of why we wanted to get into this business. As you know, the eCQM measures start in January. Hospitals are really behind the curve on this right now. We estimate that probably 10% to 15% of hospitals have some kind of program up and running, and we believe that Monarch presents a better algorithm than others.

All the papers that have been published indicate to us that this is a better platform. We think there's a tremendous opportunity for us to leverage where Glooko is at the enterprise level with these hospitals, where Monarch is in the hospital systems, and to get the marketing message out on the need for the patient safety component and the compilation and ranking of hospital safety data at the end of 2026. I don't know of any CMO who wants to be on the bottom of that list. They want to make sure patient safety is first and that they did have a good decision-making tool in order to inform improvements. So, that's exactly why we thought this was a good fit and a timely acquisition for us as well. We're three months away from the eCQM measures being collected.

Interview with Dr. Mark Clements

On the integration's support of primary care and population health management

Jeremy: Thank you for meeting with us to offer additional color on this exciting integration. To start, beyond hospitals and specialty care, do you expect this integration will support Glooko's existing presence in primary care and broader population health management?

Dr. Mark Clements, CMO: We know that primary care physicians are really doing the bulk of diabetes care across the country. They're not specialists, but they manage type 2 diabetes, where advanced technologies like CGMs and patch pumps are rapidly gaining traction.

The first thing I think about is the need for extenders of medical care teams to fill the gap between hospital discharge and that first follow-up appointment. We also need to empower people with diabetes with more educational materials. Many are now being discharged after a new diagnosis with advanced technologies like CGM, and I expect we'll see more and more discharged with additional tools in the future. That means the burden of education and onboarding becomes critical. Having a digital health tool – or suite of tools – that connects patients back to their medical home early, coupled with population health management strategies, is key to filling those gaps. That discharge-to-first-appointment period is very important for both newly diagnosed patients and those with established diabetes.

Esther: We completely agree. We were also really interested in how recommendations have increased acceptance of diabetes technologies, like CGMs and AID systems, in inpatient care with proper monitoring. How do you see Glooko and this acquisition interacting with the evolving role of inpatient diabetes technology?

Dr. Clements: There are a couple of critical transition points where having both product solutions under the same roof really makes a difference.

One is at admission. When a patient is admitted, the clinical team is first trying to stabilize them and understand what brought them in. Wouldn't it be great if, for someone with diabetes already on the Glooko platform, the inpatient team could immediately see what their diabetes self-management looked like in the days and weeks leading up to admission? I think that would be enormously helpful.

Another point is insulin dosing. EndoTool isn't technically a machine-learning algorithm, but it's a series of multi-variable statistical algorithm that personalizes insulin dosing for different cohorts of individuals based on an individual's characteristics and health state. If you could add information about insulin usage in the 24 hours prior to admission, you could get patients to the right dosage and to target glucose faster and with fewer errors than starting from guesswork.

Finally, discharge is also key. Health systems in the US are very interested in properly preparing people for discharge

and reducing 30-day readmission rates. If you could combine inpatient data with the first few days post-discharge, you could classify risk more efficiently and apply risk-based care protocols.

And in between admission and discharge, large hospital systems, both at a mid-level and globally, are building patient progression hubs, or command centers, to monitor health and risks across their entire population. Imagine integrating inpatient and outpatient glycemic data to inform future algorithms and detect emerging risks during hospitalization. That could help clinicians act sooner, prevent deterioration, and apply protocols more effectively.

This excites me because I'm a population health advocate, and I believe in better living through algorithms. Clinicians carry a heavy cognitive burden in complex systems. We should be designing tools that act as extenders of clinical teams, helping them make the right decisions faster to improve safety and outcomes.

Esther: Thank you so much for that — it's really interesting to hear your characterization of the role of personalized treatment in inpatient and outpatient care, and how insulin dosing can be tailored to each person with these technologies.

Dr. Clements: I want to be clear: what the EndoTool algorithm does today is personalize recommended insulin doses to the individual's health state. That's unique among algorithms used in the hospital setting. Some of the population health and risk-forecasting ideas I mentioned don't exist yet, but those are exciting future directions to build toward.

On patient progression hubs

Colson Duncan: Thank you for this clarification, it's an incredibly interesting vision for where the field is headed. You mentioned patient progression hubs, or command centers. Could you tell us a bit more about how those work in practice?

Dr. Clements: Of course. Many hospitals are building out these command centers because the hospital bed and the hospital services are finite resources. Administrators face a conundrum: they need to expand bed counts to serve their communities, but at the same time, the goal of healthcare is empty beds – that means preventive care is working. They want to make sure they are utilizing hospital resources effectively, which means that if you have individuals with lengthened hospital stays, possibly because a medical error like a hypoglycemic episode occurred that delayed their discharge from the hospital, then you're not utilizing that resource in the most effective and efficient way possible.

Command centers give nursing supervisors, hospital administrators, and other in-hospital leadership a bird's-eye view of how patients are moving through their hospital stay. Are they getting better? Are they getting worse? Do the states of health and the acuity of conditions on any unit in the hospital match with the staffing and other resources allocated at that moment?

Hospitals and these centers don't just monitor vital signs. They look at things like the weather, which can affect airlift patients, or social needs that might contribute to a delayed discharge. It's a systems-level view of risk, flow, and resource utilization.

Kelly: That was like poetry.

On the inpatient insulin dosing algorithm competitive landscape

Jeremy: With all of that additional detail you've shared about EndoTool, its integration with Glooko's platform, and the goal of hospitals and the steps they are already taking to reduce hypo- and hyperglycemic crises, I started thinking about the broader competitive landscape in terms of inpatient insulin dosing algorithms. Could you comment on the other technologies or software in this space, and a bit more on how EndoTool is differentiated?

Dr. Clements: EndoTool is a unique algorithm in the field. Many approaches to digitizing inpatient insulin titration were derived more than 20 years ago from the digitalization of paper protocols. A lot of those paper protocols used a gain factor or a multiplier to determine what the next insulin dose should be. So, those algorithms tend to be simple – a one-size-fits-all approach.

EndoTool is different in two key ways. First, it has a long history of evidence and publications demonstrating its effectiveness, which you see looking across its website. Second, it uses different algorithms for different populations and settings: IV insulin therapy in critical care units, subcutaneous insulin in non-critical care, even specialized versions for

individuals with diabetes and a comorbid renal insufficiency that adjust dosing based on estimated residual extracellular insulin. That's a level of algorithmic personalization that I haven't seen yet with other algorithms.

Looking forward, I also think this move is important for Glooko because the field is evolving to include CGM-based monitoring in the inpatient setting. Frankly, I think there may come a day when we see some form of insulin pumps approved and used in inpatient settings, even for people who are experiencing dysglycemia for the first time. When these changes come sooner or later, we want to be there as a company that has built its name on expertise in integrating data from any device in the ecosystem.

Jeremy: Thank you so much for your time, we greatly appreciate all of these insights you could share on the state of healthcare today and the direction its heading. We look forward to seeing more from the integration as it begins to roll out in the US.

--by Jeremy Alkire, Colson Duncan, Kat Moon, Esther Min, and Kelly Close