

DiabetesEd Services ONLINE UNIVERSITY

Optimizing GLP-1 Therapy with Lifestyle: A Practical Clinical Approach 2026

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www.DiabetesEd.net

ADA Standards of Care



Standards of Care in Diabetes—2026



9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026 [PDF](#)
American Diabetes Association Professional Practice Committee for Diabetes*

4. Comprehensive Medical Evaluation and Assessment of Comorbidities: Standards of Care in Diabetes—2026 [PDF](#)
American Diabetes Association Professional Practice Committee for Diabetes*

Topics

1. Provide person-centered care that effectively considers body weight and glycemic goals.
2. Utilize a judgement-free approach when providing counsel on lifestyle and behavior change.
3. State the optimal use of GLP-1s to improve health outcomes and overall well-being.



Diabetes Visit – What do you think?

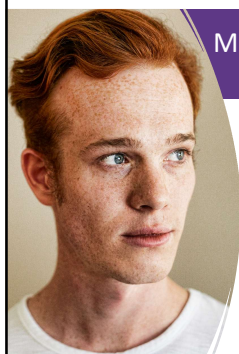
- ▶ JR arrives at the clinic and is reluctant to get weighed. They have type 2 diabetes and are struggling to lose weight.
- ▶ HCP says “Wow, looks like you put on a few pounds since our last visit. I thought you met with the RDN to learn about healthy eating?”

How Does JR Feel?

- ▶ Defeated
- ▶ Embarrassed
- ▶ Ashamed
- ▶ Angry
- ▶ Hurt



How does the HCP feel?



Missed Appointments due to Stigma and Shame

A recent survey of over 2,600 people with diabetes across eight countries revealed that nearly 40% of missed doctor’s appointments are due to stigma or shame.

Abbott. (2025, February 4). Abbott’s Above the Bias film reveals misconceptions can impact diabetes care. <https://abbott.mediaroom.com/2025-02-04-Abbotts-Above-the-Bias-Film-Reveals-Misconceptions-Can-Impact-Diabetes-Care>

Create a Judgement Free Zone – Roll out the Carpet of Acceptance

There are no bad or good blood glucose numbers.

There is no such thing as cheating.
You are not failing at your diabetes.
It is not your fault you have diabetes.
Thank you for showing up today.



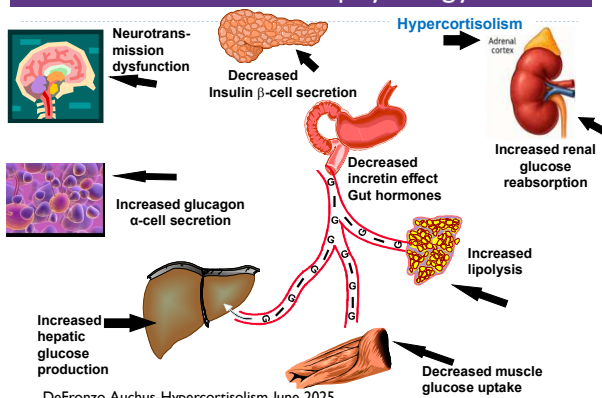
Commit to
Listening
at least
Half of the
Time



No one can give themselves diabetes.



The Noxious Nine – Pathophysiology T2D



ADA 2026 Summary

A1c less than 7%
(individualize)

- Pre-meal BG 80-130
- Post meal BG <180
- Time in Range (70-180) >70%

Glycemic targets need to be woven into the overall person-centered strategy.

BP <130/80 or <120/80



Cholesterol

- Statin therapy based on age & risk status
- If 40+ with ASCVD Risk, decrease LDL by 50%, LDL <70
- If 40+ with ASCVD, decrease LDL by 50%, LDL <55

Diabetes Visit – Let's Go through

- ▶ JR has type 2 diabetes and are struggling to lose weight. Their weight increased a few pounds since last visit.

A small adjustment can make a BIG Difference

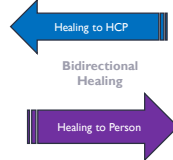
- ▶ HCP smiles and says, "Hi JR, good to see you. I heard you met the dietitian? How did that go?"
- ▶ JR, "It went great. I just can't seem to lose weight. My friend mentioned they are on a once-a-week injection?"
- ▶ Door Open – Connection made

How Does JR Feel?

- ▶ Heard & Seen
- ▶ Recognized
- ▶ Connected



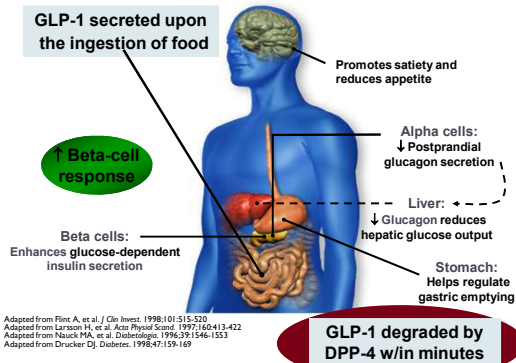
How does the HCP feel?



GLP & GIP Receptor Agonists



GLP-1 Effects in Humans Understanding the Natural Role of Incretins



Pocket Card: GLP-1 & GIP RA

GLP-1 & GIP for Diabetes & Weight Loss

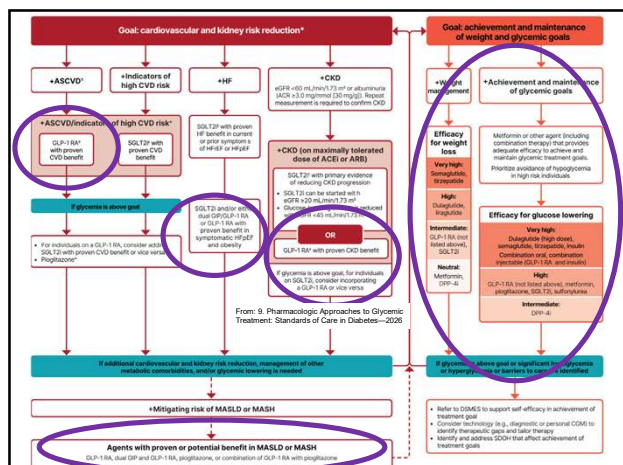
Class/Action	Generic Name	Diabetes Version Dose - Indication	Wt loss Version Indications	Considerations
GLP-1 RA - Glucagon Like Peptide Receptor Agonist "Incretin Mimetic" • Increases insulin release with food • Slows gastric emptying • Promotes satiety • Suppresses glucagon	exenatide 2x day injection	exenatide 5 and 10 mcg		Side effects: N/V, wt loss. Report signs of pancreatitis or ileus, stop med. Black box warning: Avoid if family history medullary thyroid tumor. *Reduces risk of CV Disease, death, MI, Stroke †Approved for peds 10-17 yrs Lowers A1C ~ 0.5 - 1.6% Wt loss: 4-9% (Diabetes versions)
	liraglutide 1x day injection	Victoza*† 0.6, 1.2, 1.8mg	Saxenda Peds 12-17	
	dulaglutide 1x week injection	Trulicity*† 0.75, 1.5, 3.0, 4.5mg		
	semaglutide 1x week injection	Ozempic* 0.25, 0.5, 1.0, 2.0mg Tx for CKD	Wegovy Peds 12-17 Tx for MASD	
	semaglutide Daily Oral - fasting w/ H2O	Rybelsus* 3, 7, 14 mg - R1 1.5, 4, 9 mg - R2	Wegovy* Oral tablet	
GLP-1 & GIP Receptor Agonist Activates receptors for GLP-1 (see above) & Glucose-dependent Insulinotropic Polypeptide (GIP).	tirzepatide 1x week injection. Single dose via prefilled pen or vial. Gradually adjust dose based on shared decision, individual goals.	Mounjaro 2.5, 5.0, 7.5, 10, 12.5, 15 mg Gradually adjust dose based on shared decision, individual goals.	Zepbound Tx for sleep apnea	Side effects: N/V, wt loss. Report pancreatitis or signs of ileus, stop med. Black box warning: Avoid if family hx of medullary thyroid tumor. Lowers A1C ~ 1.8 - 2.4% Wt loss: 7-14% (Diabetes versions)

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Benefits of GLP-1 RA & GIP/GLP-1 Receptor Agonists

A1C lowering	Substantial Weight loss	Cardiovascular benefits*
Decreased appetite	Lowers post meal glucose	Ease of use

*semaglutide, liraglutide, dulaglutide



Discuss Weight Loss Goals

- These meds associated with weight loss:
 - GLP-1 RA and GLP/GIP agonists
 - SGLT-2 Inhibitors
- These meds are weight neutral:
 - Metformin
 - DPP-4 Inhibitors
- These meds can cause wt gain:
 - Sulfonylureas
 - Insulin
 - Pioglitazone

Goal: achievement and maintenance of weight and glycemic goals

- Weight management**
 - Efficacy for weight loss**
 - Very high: Semaglutide, tirzepatide
 - High: Dulaglutide, liraglutide
 - Intermediate: GLP-1 RA (not listed above), SGLT2
 - Neutral: Metformin, DPP-4
- Achievement and maintenance of glycemic goals**
 - Metformin or other agent (including combination therapy) that provides adequate efficacy to achieve and maintain glycemic treatment goals. Prioritize avoidance of hypoglycemia in high-risk individuals.
 - Efficacy for glucose lowering**
 - Very high: Dulaglutide (high dose), semaglutide, tirzepatide, insulin
 - High: GLP-1 RA (not listed above), metformin, pioglitazone, SGLT2, sulfonylureas
 - Intermediate: DPP-4

glycemia to above goal or significant hypoglycemia or hyperglycemia or barriers to care are identified

GLP-1 /GIPs Approved for Weight Loss

- Liraglutide:**
 - Victoza 1.8 mg (diabetes)
 - Saxenda 3 mg (wt loss)
 - 6% wt loss
- Semaglutide:**
 - Ozempic 2mg (diabetes)
 - Wegovy 2.4mg (wt loss)
 - 9.6% wt loss
- Tirzepatide**
 - Mounjaro 15mg (diabetes)
 - Zepbound (wt loss)
 - 14.7% wt loss

All 3 Approved for use in adults with a:

- BMI of ≥ 30 or
- BMI of ≥ 27 or greater who have hypertension, type 2 diabetes, or dyslipidemia.

Poll 1

RT is on max dose of metformin and is started on tirzepatide to help with BMI of 39 and decrease CV risk. What outcomes can KR expect at highest dose?



- a. A1C drop of 3-4%, Wt loss of 3-5kg
- b. Increased risk of UTI, A1C drop of 1-2%
- c. Potential for ~10% body wt loss
- d. Doubles risk of pancreatic cancer

GLP-1/GIP Receptor Agonist Indications

Drug	Lower BG Diabetes Version	CV Indication	Wt Loss Version	Other
Exenatide IR (Byetta)	Yes	No	No	
Dulaglutide (Trulicity)	Yes for 10 yrs and older	Yes	No	
Semaglutide (Ozempic, Rybelsus Wegovy)	Yes Ozempic Rybelsus	Yes-all versions	Yes Wegovy 2.4mg, 12yrs and over	MASH-Wegovy CKD-Ozempic
Liraglutide (Victoza)	Yes for 10 yrs and older	Yes	Yes Saxenda 3mg 12yrs and over	
Tirzepatide (Mounjaro, Zepbound)	Mounjaro Yes for 10 yrs and older	No	Yes, Zepbound 15 mg	Sleep Apnea-Zepbound

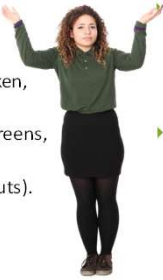
Package inserts, dailymed.nlm.nih.gov

Are GLPs a lifelong commitment?

- ▶ About 50% - 75% of people stop taking their GLP/GIP by 1 year
 - ▶ Due to cost, side effects, access, impact on food desire
- ▶ Results in weight regain back to baseline by ~18 months (about 1lb regain a week)
- ▶ What are some suggestions?
- ▶ Involve the individual in all decision making
 - ▶ Address nausea
 - ▶ Slowly increase dose only after careful discussion
 - ▶ Once reach goal weight, consider microdosing or increasing length of time between doses.
 - ▶ Consider oral version

Nutrition Issues

- ▶ Regular visits with RDN are critical part of care plan.
- ▶ Prioritize high-protein, nutrient-dense foods
 - ▶ Lean proteins (fish, chicken, eggs, tofu)
 - ▶ High-fiber foods (leafy greens, whole grains)
 - ▶ Healthy fats (avocado, nuts).
- ▶ Promote fluid intake, hydration
- ▶ Maintain muscle mass through strength training



- ▶ Can decrease binge eating.
- ▶ Can decrease craving for alcohol & other substances:
 - ▶ nicotine, cannabis, and opioids
- ▶ More research needed.
- ▶ Be on the look out for disordered eating.

Obesity in Type 1 Diabetes



Prevalence of Extra Weight in Type 1

- ▶ 30-40% with overweight
- ▶ 15-20% with obesity
- ▶ matching general adult statistics.

Increased Health Risks

Obesity in people with type 1 diabetes raises the risk of cardiovascular and microvascular complications, impacting overall health.

Promising Treatments

Clinical trials show GLP-1 RA therapies and metabolic surgery offer positive outcomes for type 1 diabetes

8. Obesity and Weight Management for the Prevention and Treatment of Diabetes: Standards of Care in Diabetes-2024

Treatment of Obesity in Type 1 Diabetes

8.29 Apply obesity management strategies used in the general adult population for adults with type 1 diabetes who have obesity (BMI ≥ 30 , or ≥ 27.5 in Asian American individuals).

Treatments can include:

- ▶ GLP-1 RA-based therapy
- ▶ Metabolic surgery.



Shared decision-making informs individualized care.

8. Obesity and Weight Management for the Prevention and Treatment of Diabetes

Types of Disordered Eating in Individuals with Diabetes

1. Severe Dietary Restriction
—Severe limitation of calories or essential macronutrients in the diet
2. Objective Binge Eating
—Consuming an unusually large amount of food in a short period while feeling out of control
3. Subjective Binge Eating
—Feeling a loss of control over eating without necessarily consuming large quantities of food
4. Other Maladaptive Weight Control Strategies
—Restricting life-saving insulin

<https://pmc.ncbi.nlm.nih.gov/articles/PMC10538145/>

Eating Disorders and Diabetes: Facing the Dual Challenge
Roshellina James¹, Barbara Beckel², Marissa Hirsch³, Emma Fothergill-Giles⁴

JR Asks You

- ▶ I heard these meds can cause liver or kidney problems?



Counseling Points: GLP-1 RA & GLP-1/GIP

- ▶ Avoid if personal or family history of medullary thyroid cancer or personal history of Multiple Endocrine Neoplasia type 2 (MEN-2)
- ▶ Avoid in combo with DPP-4 inhibitors
- ▶ Watch for intestinal obstruction
- ▶ Increased risk of biliary disease
- ▶ Education: Eat smaller meals to reduce nausea and limit high fat meals
- ▶ Use of non-FDA *compounded* products not recommended



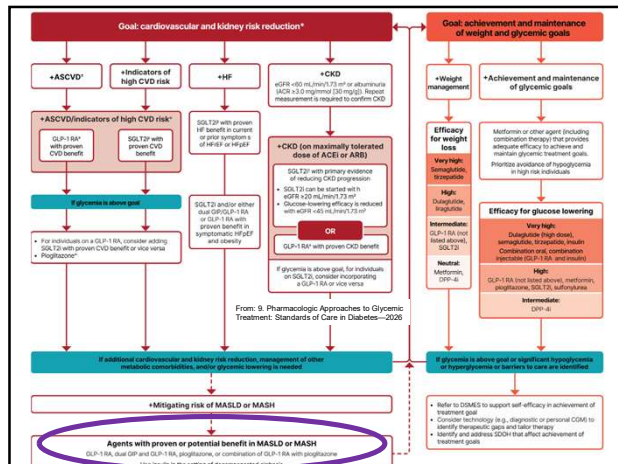
From: 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026

Counseling Points: GLP-1 RA & GLP-1/GIP

- ▶ Potential risk of pancreatitis
- ▶ Can cause diarrhea or constipation
- ▶ If on tirzepatide and oral contraceptives, use back up contraception for first 4 weeks
- ▶ Warning about aspiration during surgery
- ▶ Ask about recent eye exam
 - ▶ Potential increase in diabetes retinopathy
 - ▶ Nonarteritic anterior ischemic optic neuropathy (NAION) reported (rare incidence)



From: 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026



Mitigating Risk of MASLD or MASH

If additional cardiovascular and kidney risk reduction, management of other metabolic comorbidities, and/or glycemic lowering is needed

+Mitigating risk of MASLD or MASH

Agents with proven or potential benefit in MASLD or MASH
GLP-1 RA, dual GIP and GLP-1 RA, pioglitazone, or combination of GLP-1 RA with pioglitazone
Use insulin in the setting of decompensated cirrhosis

- ▶ MASLD: metabolic-dysfunction associated steatotic liver disease
- ▶ MASH: Metabolic-dysfunction associated steatohepatitis

From: 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026

Pocket Card: GLP-1 & GIP RA

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Liver Disease: MASLD or MASH

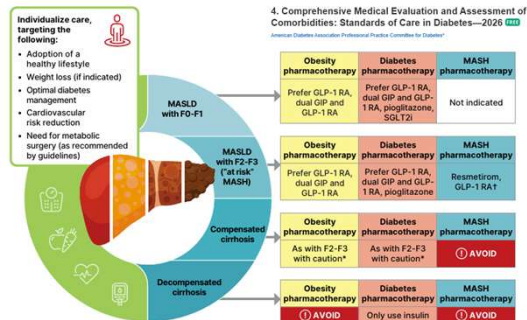
- In adults with T2D, MASLD and overweight/obesity,
 - Consider using a GLP-1 RA with demonstrated benefits in MASH
 - Or a GLP-1/GIP RA with potential benefits for MASH
- In adults with biopsy proven MASH,
 - GLP-1 RA is preferred.
 - Pioglitazone or a dual GIP/GLP-1 RA can be considered for glycemic management due to potential beneficial effects on MASH.
- Insulin preferred for decompensated cirrhosis

Semaglutide
Tirzepatide
Pioglitazone

4. Comprehensive Medical Evaluation and Assessment of Comorbidities: Standards of Care in Diabetes—2026

MASLD Treatment (Section 4 SOC)

Metabolic dysfunction-associated steatotic liver disease (MASLD) treatment algorithm



Life Study

- ▶ 71-year-old woman with type 2 diabetes for past year. BMI 32 and she has MASH. GFR 40s, UACR 320 mg/g. Takes empagliflozin, lisinopril and a statin.
- ▶ A1c 8.3%
- ▶ What is next best action?



- A. Add pioglitazone.
- B. Maintain current plan.
- C. Add semaglutide
- D. Start low dose metformin

Indicators of High CV Risk

- Over 55 years with 2 or more additional risk factors:
 - Obesity
 - Hypertension
 - Smoking
 - Dyslipidemia
 - Albuminuria



Cardiovascular Disease or High Risk

Goal: cardiovascular and kidney risk reduction*

+ASCVD†

+Indicators of high CVD risk

+ASCVD/indicators of high CVD risk*

GLP-1 RA* with proven CVD benefit

SGLT2i* with proven CVD benefit

If glycemia is above goal

For individuals on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit or vice versa

• Pioglitazone*

ASCVD = atherosclerotic cardiovascular disease
MACE = major adverse cardiovascular events

Most effective meds based on Cardiovascular Outcomes Trial (CVOT) to Reduce MACE

GLP-1 RA's Preferred
semaglutide (Ozempic),
liraglutide (Victoza),
dulaglutide (Trulicity)

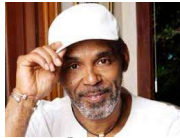
~ Or ~

SGLT2i
empagliflozin (Jardiance),
canagliflozin (Invokana),

Poll Question 2

►What next? 67 yrs, BMI 28, on max dose metformin/dapagliflozin. History of CV Disease. A1c 8.9%. GFR 63, UACR 37mg/g.

- Add a once weekly GLP-1 RA.
- Start basal insulin
- Add SGLT-2 Inhibitor
- Start bolus insulin



Heart Failure

+HF

SGLT2i with proven HF benefit in current or prior symptoms of HFpEF or HFrEF

SGLT2i and/or either dual GIP/GLP-1 RA or GLP-1 RA with proven benefit in symptomatic HFpEF and obesity

In people with heart failure, use SGLT2i because they improve heart failure and kidney outcomes.

New for 2026:

9.9 In adults with T2D, obesity, and symptomatic HFpEF, the glucose-lowering treatment plan should include a GIP/GLP-1 agonist or GLP-1 agonist with demonstrated benefits for HF-related symptoms and reduction in HF events (irrespective of A1C).

GLP-1 RA
Semaglutide
GLP-1/GIP RA
Tirzepatide

SGLT2i
Empagliflozin
Canagliflozin
Dapagliflozin
Ertugliflozin

From: 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026

Chronic Kidney Disease - Choosing glucose-lowering medication

+CKD
eGFR <60 mL/min/1.73 m² or albuminuria (ACR ≥3.0 mg/min/1.73 m²). Repeat measurement is required to confirm CKD

+CKD (on maximally tolerated dose of ACEi or ARB)

SGLT2i with primary evidence of reducing CKD progression

- SGLT2i can be started with eGFR ≥20 mL/min/1.73 m²
- Glucose-lowering efficacy is reduced with eGFR <45 mL/min/1.73 m²

OR

GLP-1 RA* with proven CKD benefit

If glycemia is above goal, for individuals on SGLT2i, consider incorporating a GLP-1 RA or vice versa

In kidney disease, use SGLT-2 in people with GFR ≥ 20 and continue until initiation of dialysis or transplantation.

(When GFR <45, SGLT-2's don't lower BG much.)

Or
GLP-1 RA with proven CVD CKD benefit

*Semaglutide improves kidney function (FLOW trial)

From: 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026

New in 2026: GLP-1 in Kidney Disease

- In adults with T2D and advanced CKD (eGFR <30), a GLP-1 RA is preferred for glycemic management due to lower risk of hypoglycemia and for CV event reduction.
- Individuals on dialysis can be safely initiated or continued on GLP-1 based therapy to reduce CV risk and mortality
- Reminder: only GLP-1 with renal restrictions are exenatide and lixisenatide



From: 8. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2026

Overcoming Treatment Inertia



8. Glycemic and Weight Management for the Prevention and Treatment of Diabetes: Standards of Care in Diabetes—2026

Reassessing Current Therapies

Regularly evaluate treatment effectiveness to avoid stagnation and ensure progression toward their weight-related and health goals.

Intensifying Treatment Strategies

Consider adding behavioral interventions or pharmacotherapy to boost treatment effectiveness

Considering Metabolic Surgery

Metabolic surgery may provide an effective next step for sustained weight control when other options are insufficient.

- **Randomized controlled (nonblinded) clinical trials** demonstrated metabolic surgery achieves:

- Superior glycemic management and reduction of cardiovascular risk in type 2 diabetes compared with nonsurgical intervention.
- Decreases microvascular, cancer, all cause mortality and steatosis.

Keep checking in

- ▶ In all cases, treatment plans need to be continuously reviewed for efficacy, side effects, and burden.
- ▶ Individual may require medication reduction or discontinuation.
- ▶ Common reasons for this include ineffectiveness, intolerable side effects, new contraindications, expense, or a change in glycemic goals





Keeping it Person Centered is beneficial for both the Receiver & Giver

We Can Make a Big Difference

We can make a difference in moving care forward.

Through behavior change, coaching, and advocating for best care, we can improve well-being, decrease complications and improve quality of life!



Thank You



► Thanks for joining us!

► Please let us know if we can be of more service

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