

# DiabetesEd Services ONLINE UNIVERSITY

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

Beverly Thomassian, RN, MPH, CDCES, BC-ADM  
[www.DiabetesEd.net](http://www.DiabetesEd.net)

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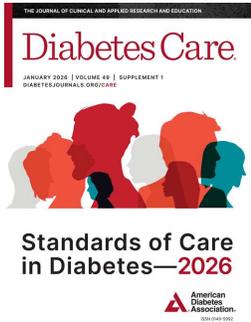
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# ADA Standards of Care



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\*

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# 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.



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## 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?

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## 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-FilmReveals-Misconceptions-Can-Impact-Diabetes-Care>

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## 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.



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Commit to Listening at least Half of the Time




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No one can give themselves diabetes.




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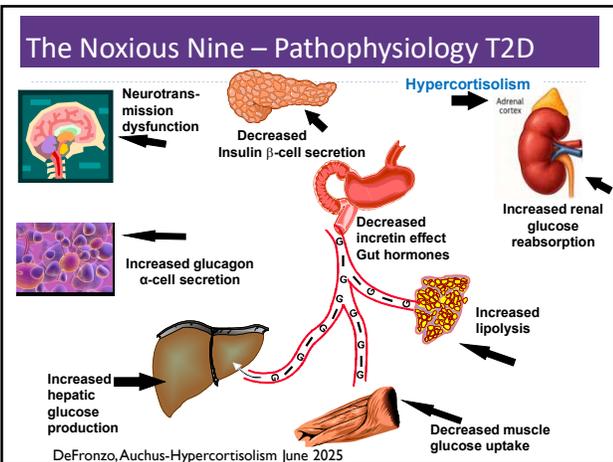
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## ADA 2026 Summary

<p><b>A1c less than 7% (individualize)</b></p> <ul style="list-style-type: none"> <li>Pre-meal BG 80-130</li> <li>Post meal BG &lt;180</li> <li>Time in Range (70-180) &gt;70%</li> </ul> <p style="font-size: small; color: #4f81bd;"><i>Glycemic targets need to be woven into the overall person-centered strategy.</i></p>	<p><b>BP &lt;130/80 or &lt;120/80</b></p> 	<p><b>Cholesterol</b></p> <ul style="list-style-type: none"> <li>Statin therapy based on age &amp; risk status</li> <li>If 40+ with ASCVD Risk, decrease LDL by 50%, LDL &lt;70</li> <li>If 40+ with ASCVD, decrease LDL by 50%, LDL &lt;55</li> </ul>
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## 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.

**How Does JR Feel?**

- ▶ Heard & Seen
- ▶ Recognized
- ▶ Connected



**How does the HCP feel?**



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

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## GLP & GIP Receptor Agonists



Reduce Major Adverse Cardiovascular Events (MACE)

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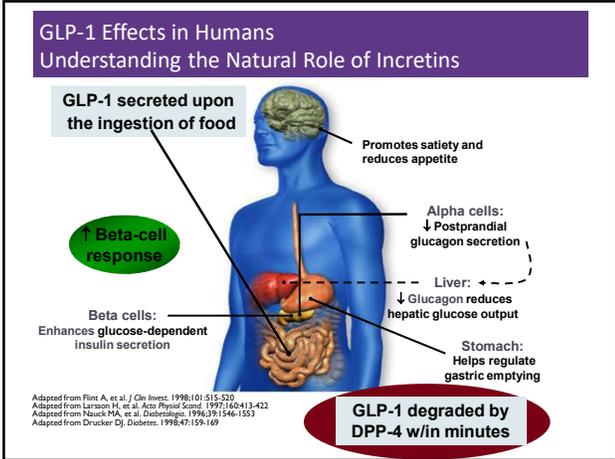
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### Pocket Card: GLP-1 & GIP RA

#### GLP-1 & GIP for Diabetes & Weight Loss

Class/Action	Generic Name	Diabetes Version Dose - Indication	Wt loss Version Indications	Considerations
<b>GLP-1 RA - Glucagon Like Peptide Receptor Agonist</b>  *Incretin Mimetic* • Increases insulin release with food • Slows gastric emptying • Promotes satiety • Suppresses glucagon	exenatide	exenatide 2x day injection 5 and 10 mcg		<b>Side effects:</b> N/V, wt loss. Report signs of pancreatitis or ileus, stop med.  <b>Black box warning:</b> 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	Victoza**† 1x day injection 0.6, 1.2, 1.8mg	Saxenda Peds 12-17	
	dulaglutide	Trulicity**† 1x week injection 0.75, 1.5, 3.0, 4.5mg		
	semaglutide	Ozempic* 1x week injection 0.25, 0.5, 1.0, 2.0mg Tx for CKD	Wegovy Peds 12-17 Tx for MASB	
	semaglutide	Rybelsus* Daily Oral - fasting w/ H2O 3, 7, 14 mg - R1 1.5, 4, 9 mg - R2	Wegovy* Oral tablet	
<b>GLP-1 &amp; GIP Receptor Agonist</b>  Activates receptors for GLP-1 (see above) & Glucose-dependent Insulinotropic Polypeptide (GIP).	tirzepatide	Mounjaro 1x week injection. Single dose via prefilled pen or vial.  Gradually adjust dose based on shared decision, individual goals.	Zepbound Tx for sleep apnea	<b>Side effects:</b> N/V, wt loss. Report pancreatitis or signs of ileus, stop med.  <b>Black box warning:</b> 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

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## 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

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## GLP-1/GIP Receptor Agonist Indications

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

Package inserts, dailymed.nlm.nih.gov

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## 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

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## 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.

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## 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-2025

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## 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  $\geq 30$ , or  $\geq 27.5$  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

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## 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

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## Indicators of High CV Risk

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




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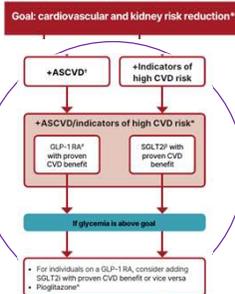
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## Cardiovascular Disease or High Risk



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),

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## 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.

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




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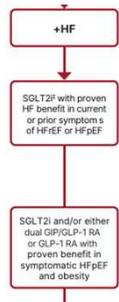
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## Heart Failure



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

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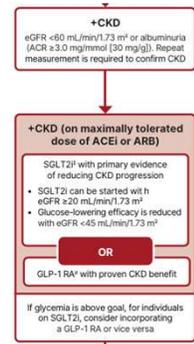
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## Chronic Kidney Disease - Choosing glucose-lowering medication



In kidney disease, use SGLT-2 in people with GFR  $\geq 20$  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

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## 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

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## Overcoming Treatment Inertia



### 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.

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

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## 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



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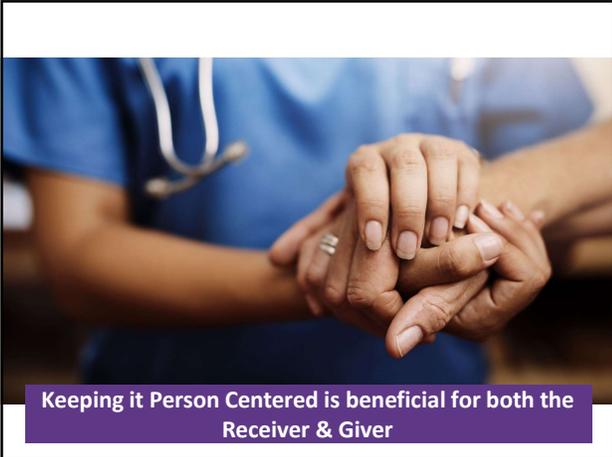
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**We Can Make a Big Difference**

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!



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**Thank You**



- ▶ Thanks for joining us!
- ▶ Please let us know if we can be of more service
- ▶ [www.DiabetesEd.net](http://www.DiabetesEd.net)
- ▶ [info@diabetesed.net](mailto:info@diabetesed.net)
- ▶ 530 /893-8635



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