

MARCH 2026 - ISSUE 10

# GLYCEMIC ROOTS

## KEEPING DIABETES EDUCATORS CONNECTED

Waterloo Wellington Diabetes Newsletter



The WRHN PREVENT clinic is a proactive Nurse Practitioner-led multi-disciplinary team, (NP, RD, RT, Pharm, SW, R.Kin) located at the Boardwalk in Waterloo. The clinic helps to support patients with risk factors of cardiovascular disease in making lifestyle and behavioural changes to improve current health and lower their future risk.

WRHN PREVENT Clinic has now expanded their referral criteria to include prevention of diabetes along with cardiac disease risk factors. As well, Diabetes Educators **can now** refer patients who meet the criteria directly!

The clinic offers three months of health prevention services which include:

1. Individualized exercise program with on-site supervised exercise classes
2. Individual dietary guidance
3. Smoking cessation counselling
4. Clinical assessment and preventative medical therapy
5. Health system navigation

By the end of the program, patients will be provided with resources and community programs to continue their prevention journey and follow up with their primary care provider. If the patient does not have a primary care provider, the clinic's social worker will try to connect patients with a primary care provider during the program.

**\*\*Patients must be able to provide their own transportation to the PREVENT Clinic, located at 430 The Boardwalk, Medical Center 2, Suite 308, Waterloo ON \*\***

In addition to Physicians and Nurse Practitioners, diabetes educators **will now** be able to refer patients with prediabetes, a history of GDM or type 2 diabetes and who live in Kitchener-Waterloo, Wellington County, Guelph or Stratford regions and meet two of the following cardiovascular risk factors:

- Type 2 diabetes
- Hypertension
- Dyslipidemia or confirmed familial hypercholesterolemia
- Family history of early-onset coronary disease (age < 60) in a first-degree relative
- Current smoker

Referrals can be made using the PREVENT clinic DEP referral form, [click here](#). Share the PREVENT Clinic Flyer below with your patients, [click here](#).

For further information the PREVENT Clinic team can be reached at 226-806-5911.

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January 30, 2026 - Toronto

# Beyond the Prescription: Single & Dual GLP-1/GIPras, Nutrition and Health Conference

## Key Takeaways

### 1. Emerging Therapies

#### a. Multi-agent therapies:

- i. GLP-1, GIP, glucagon, monoclonal antibodies and amylin in various combinations currently in clinical trials. Likely available within the next decade. Expected to have higher weight loss potential. These combination therapies will be designed to target co-morbidities through the specific combination of agents = more personalized medicine.
- ii. Monoclonal antibodies - trials showing potential that these agents may be muscle protective in weight loss.

#### b. GLP-1 producing cells: ongoing research into gene therapies and gene editing, as some individuals do not have functional GLP-1 receptors.

### 2. Assessment Considerations

#### a. Hydration Status - Review fluid intake at each touch point. Decreased kcal intake, often results in decrease fluid intake. Educate patient on fluid needs (2-3L/day), establish fluid goals to prevent dehydration and acute kidney injury.

#### b. Diet Quality - risk of inadequate protein, fibre, vitamin/mineral intake.

- i. **Protein intake** - based on new evidence, 1.2-1.5 grams of protein/kg is needed to help mitigate muscle loss/sarcopenia and encourage muscle growth. To calculate protein needs, experts advise using patients' current weight up to a BMI of 30. If BMI is over 30, calculate based on ideal weight of BMI 25. Bariatric patient data indicates > 8 kg lean body mass loss = long-term health implications. Strongly encourage resistant training to minimize muscle loss.

- ii. **Fat Intake** - at least 20% of kcal intake to mitigate gallstone formation.

- iii. **Fibre** - >21 g/day (women), >30g/day (men).

- iv. **Nutritional Deficiencies** - observational data indicates 12.7% of patients on GLP-1s had a documented nutritional deficiency by 6 months, 22.4% by one year. Most common deficiencies: iron, vitamin B12, folate, vitamin D and calcium. Deficiencies are not due to malabsorption but rather to a decrease in intake and diet quality. Measure and treat pre-existing deficiencies. Consider vitamin D, calcium and complete multivitamin supplementation.

- v. **Special Populations at Risk: Elderly** - monitor diet quality as this population is at increased risk of sarcopenic obesity. **Adolescents** - monitor diet quality due to growth and development.

#### c. Preconception - Incretin therapy can increase fertility and contraception should be discussed. If wanting to conceive, stop incretin therapy 2-3 months prior to conception as lower caloric intake could negatively impact fetus. Start pregnancy safe medications to achieve ideal blood pressure and glycemia.

### 3. Reframing Focus of Therapy

#### a. Health gained not weight lost:

- i. Address weight loss expectations. Ask your patients what their expectations of therapy are. Studies show that patients expect to lose 30-35% of body weight and would consider the therapy a failure if they only lost 15-20%!
- ii. Studies show patients need a multidisciplinary and supportive approach to ensure healthy weight loss and improved health outcomes. Shouldn't be a medication only approach.
- iii. Obesity is a disease. Patients need support to address continued societal stigma. Ensure patients understand the benefits of treatment only remain if they remain on incretin therapy, 70-75% of MASLD, CVD and CKD benefits are independent of weight lost = lifelong treatment likely required.

NEW

## Nutrition Guidance Documents for GLP-1/GIPras Therapies

1. Nutritional and Lifestyle Supportive Care Recommendations for Management of Obesity with GLP-1 based Therapies: An Expert Consensus Statement.

[Click here](#) to access

2. Nutritional Priorities to Support GLP-1 Therapy for Obesity. A Joint Advisory from the American College of Lifestyle Medicine, the American Society of Nutrition, the Obesity Medicine Association, and the Obesity Society.

[Click here](#) to access

3. Nutritional Considerations with Anti-obesity Medications.

[Click here](#) to access

## Framework for Diabetes in Canada

In October 2022, the first time in well over a decade, the Health Minister tabled the updated Framework for Diabetes in Canada.

In 2023, Diabetes Canada with funding from the Public Health Agency of Canada, launched the Sustaining Momentum to Implement the Diabetes Framework (SMIDF) project.

Over the last 3 years, Diabetes Canada SMIDF project team has brought together key stakeholders to help identify and share best practices.

Diabetes Roundtables and Summits have been held across the country. The goal is to create an inventory of Canada's most successful diabetes programs/interventions/projects to share with provincial governments.

[Click here](#) to learn about the SMIDF project

[Click here](#) to read the Summit reports

[Click here](#) to access the Framework for Diabetes in Canada

# **NEW** KidneyWise Clinical Toolkit 2026

The KidneyWise Toolkit was created and is updated by the Ontario Renal Network (ORN) to help support primary care in providing person-centred and high-quality care to people living with chronic kidney disease (CKD) in Ontario. It provides guidance on the identification, detection and management of CKD, and guidance on when to refer to Nephrology.

### The toolkit contains:

- clinical algorithm to identify and manage CKD
- clinical evidence summary
- ORN referral form
- patient information handouts on CKD and SGLT2 medications
- healthcare provider education slide decks
- medication safety list
- e-consult nephrology request

### The 2026 updates include:

- recommendation to screen black people living in Ontario yearly due to elevated risk of CKD
- a lower ACR threshold for referral to an ORN nephrologist for people who do not have diabetes
- recommendation for medications to use to manage CKD (SGLT2i, MRAs, GLP-1ras)

[Click here](#) to access the updated KidneyWise Toolkit  
[Click here](#) for the updated ORN referral form

## WaterlooWellington DIABETES At-Risk Renal Disease Initiative Update

This preventative initiative was launched in September 2025 by Waterloo Wellington Diabetes Central Intake (WWDCI) in collaboration with local community-based nephrologists in the Cambridge North Dumfries region. At-risk renal disease screening criteria was created based on the recent KDIGO and Diabetes Canada CKD guidelines. Referrers were notified of the launch of this project by an info bulletin fax.

This criteria is used by WWDCI triage clinicians to identify patients at-risk of renal disease and communicate this identified risk to referring providers with the suggestion to consider adding a nephrology consult to the referral with the aim of prevention. WWDCI indicates on the referral if renal criteria has been met to alert Diabetes Education Programs so they can educate patients on risk reduction strategies.

Over the first four months of the initiative, WWDCI received 134 nephrology consults, a 226% increase in nephrology consult requests compared to the same time frame the year before.

With the recent updates to the ORN referral criteria and KidneyWise Toolkit, WWDCI has updated the screening criteria accordingly and are now working on expanding this prevention initiative across the Waterloo Wellington region in the coming months.



### 1. CDE Exam Preparation Sessions

**Virtual**  
March 25, April 8, April 22 and May 6, 2026: 12-1 pm  
[Click here](#) to learn more and register

### 2. Rare Forms of Diabetes

**Virtual**  
April 7, 2026: 1:00-1:45 pm  
[Click here](#) to learn more and register

### 3. Charles H. Best - State of the Art Management of T1D in Adults

**Virtual or In-Person**  
Hilton Toronto/Markham Suites Conference Centre  
April 17, 2026  
[Click here](#) to learn more

### 4. Diabetes Educator Collaborative: The Cardiovascular and Metabolic Impact of Insomnia

**In-Person**  
Speaker: Dr. Alice Cheng  
Charcoal Steakhouse Kitchener  
April 16, 2026: 6:30-8:30 pm  
[Click here](#) to learn more and register

### 5. Leadership Sinai Centre for Diabetes CDE Exam Simulation

**Virtual**  
April 21 & 28, 2026: 12:00-4:15 pm  
[Click here](#) to learn more and register

### 6. Diabetes + Mental Health Conference

**Virtual**  
May 1 & 2, 2026  
[Click here](#) to learn more and register

### 7. Parents Supporting Parents

**Virtual or In-Person**  
Langs Community Health Centre  
May 25, 2026  
**For more information & to register:**  
call 519-653-1470 ext. 285

Want to learn how the **Self-Management Program** can benefit you, your patients & program? Contact Kyla at [kylap@lange.org](http://kylap@lange.org) or call 519-947-1000 ext. 265

## Community Partner Program Updates



Indigenous Diabetes Health Circle

### Diabetes 101 Course

Indigenous Diabetes Health Circle (IDHC) is an Ontario-based Indigenous governed organization whose vision is to strengthen Indigenous community capacity to reduce the impact of diabetes by providing tools, knowledge and ability to make healthy choices, through holistic and culturally appropriate care.

IDHC is offering a free, self-paced 30-minute virtual diabetes course that explores the fundamentals of diabetes through an Indigenous health belief lens, incorporating traditional knowledge and holistic approaches to wellness. The course may be of interest to indigenous community members, care partners and healthcare providers who want to deepen their understanding of Indigenous health beliefs.

[Click here](#) to learn more and register

## Resetting The Dial in Diabetes Management in Long-term Care

Many older adults living in long-term care (LTC) homes in Ontario have T2D and > 50% of LTC residents are treated to intensive glycemic targets (A1C < 7%). This puts LTC residents living with diabetes at risk of harm (hypoglycemia, falls, cognitive issues, and hospitalizations).

#### Current LTC statistics:

- 627 LTC homes in Ontario with approximately 78,000 residents
- >50,000 people on LTC waitlist for a mean 201 days
- Average age of LTC residents is 83 years, 55% of LTC residents > 85 years
- 75% have documented dementia or cognitive impairment
- 35% have a diagnosis of diabetes

The DIAL study is currently underway, a multi-phase project aims to develop and evaluate a diabetes de-intensification intervention with LTC residents, caregivers, LTC staff and healthcare providers.

To learn more about deprescribing in LTC and helpful resources visit:

[deprescribing.org](http://deprescribing.org)

If you are interested in being involved in a Diabetes Management in LTC working group, please express your interest to Trina ([trinaf@lange.org](mailto:trinaf@lange.org)).



Wishing for a warm and early spring,

Trina



### Exercise Classes for Older Adults

Free, evidenced-based exercise programs that supports building strength, balance, mobility, and confidence.

Two programs are currently available.

1. **Seniors Exercise Class:** Instructor-led aerobic, resistance, and balance training. Suitable for a wide range of fitness levels
2. **Fall Prevention Program:** Kinesiologist-led program offering education and structured strength and balance training.

Sessions are offered in community locations and virtually across Waterloo Wellington region.

[Click here](#) to learn more



### Providing Safe Indigenous Diabetes Care Infographic

The final version of the infographic is now complete. It now includes timeline stories for First Nations, Inuit and Metis communities, Indigenous artists' reflections and information on how best to incorporate these learnings into clinical practice.

[Click here](#) to access the infographic

[Click here](#) to access the Indigenous artists' reflections



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