D-PATH STUDY NEWSLETTER

JANUARY 2026

STUDY PROGRESS

Thank you to all of our pharmacy teams that have joined the D-PATH study so far!! As of mid-January we have 35 pharmacies that have joined and 24 patients recruited.

NEW YEAR, NEW START

Along with the chilly January weather, we're seeing a quieter start to recruitment — which makes it the perfect time for our January Recruitment Blitz!

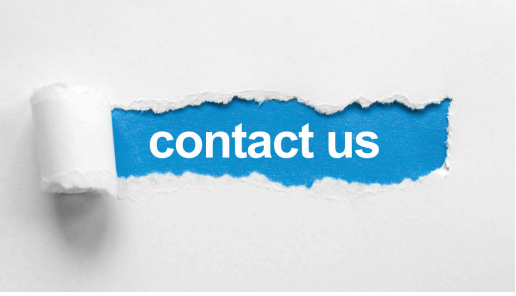
From January 1 to 31, the pharmacy that enrolls the most participants will win Tim Hortons for their entire team — a great way to warm up this winter and kick off the study strong for the new year.

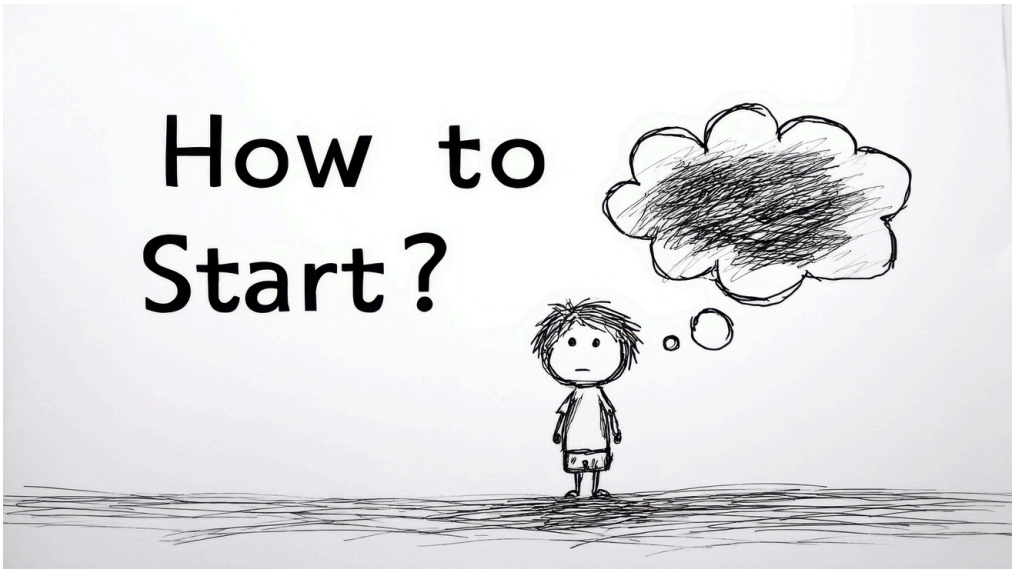
With many patients feeling especially motivated to improve their health in January, this is a wonderful opportunity to inspire them to take part in D-PATH and put their health first. Thank you for your continued commitment and enthusiasm — your efforts truly make a difference.

ONE-ON-ONE COACHING

Contact us and we can arrange a virtual call or in-person visit to go through the pathway one-on-one so you are confident before enrolling your first patient.

Email: dpathstudy@gmail.com
Phone: 825-735-9744





TARGETING THE RIGHT PATIENTS

An easy way to start recruiting is to simplify your strategy.

New diabetes prescription? A perfect opportunity.

When a patient starts a new diabetes medication, they're often more open to learning, support, and change. This is an ideal time to introduce the D-PATH study and explain how participation can provide them with extra pharmacist follow-up, education, and monitoring.

Optional recruitment script: "Our pharmacy is part of a study on pharmacist-led diabetes care. You may be eligible, and participation can help support your diabetes management. Would you like to hear more?"

Each month we will provide a recruitment strategy to help support you in recruiting patients.

A Clear Path
TO DIABETES CONTROL

WHY ACR IS SO IMPORTANT

Albumin-to-creatinine ratio (ACR) is just as important as eGFR because it detects kidney damage long before filtration declines. Many patients can maintain a normal eGFR for years while silently losing structural kidney integrity; ACR is the earliest and most sensitive marker of this injury.

Elevated albuminuria strongly predicts progression to CKD, cardiovascular events, and mortality because it reflects ongoing vascular and glomerular injury, not just reduced filtration. When albumin leaks into the urine, it signals endothelial dysfunction and inflammation within the kidneys as well as processes that also occur systemically in the heart and blood vessels. This "leakiness" correlates with accelerated nephron loss, making faster decline in kidney function more likely. At the same time, albuminuria is a powerful marker of generalized vascular disease, which is why patients with higher ACR have significantly increased risks of myocardial infarction, stroke, heart failure, and all-cause mortality; even when their eGFR is still normal. In short, albuminuria measures active damage, whereas eGFR measures remaining function, and active damage is a stronger predictor of bad outcomes.

Albuminuria is not always permanent, and that's one of the most important clinical messages. Albuminuria often reflects active, reversible kidney injury (e.g., from hypertension, diabetes, RAAS activation, inflammation, or even temporary triggers like illness, exercise, fever, or poor glycemic control). When the underlying cause is treated or controlled, albuminuria can improve substantially or even normalize. However, persistent albuminuria (≥3 months) usually indicates chronic kidney damage and carries long-term cardiovascular and renal risk, even if it improves with therapy. If a patient has had one elevated ACR, repeat the ACR in 3 months. If the repeat ACR is still elevated, persistent albuminuria is confirmed. If ACR normalizes, the initial result may have been due to a transient factor. Transient factors that can increase ACR include recent strenuous exercise, febrile illness or infection, uncontrolled hypertension or hyperglycemia, heart failure exacerbation, UTI or hematuria, dehydration.

Elevated albuminuria guides treatment decisions such as initiating SGLT2 inhibitors, ACE inhibitors/ARBs, and non-steroidal MRAs. For further information on CKD, please visit CKDpathway.ca.

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WHEN SHOULD I BOOK A FOLLOW-UP APPOINTMENT IF A PATIENT DOESN'T HAVE BLOOD WORK COMPLETED?

When sending a patient for lab work, please book their next appointment at the same time. This helps keep them motivated to complete their labs and return for their scheduled follow-up.

WHAT DO I DO IF I FOLLOW-UP MORE FREQUENTLY WITH A PATIENT THAN EVERY 6 WEEKS?

If you are seeing an Intervention group patient between follow-up visits and making any changes, these can be documented under "Notes" next to the patient's name on your site's dashboard, and then included with the next scheduled follow-up visit in 6 weeks.

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