Obesity

Quality and Innovation Collective (QuIC)

Phase 2 Meeting Summary

March 17–18, 2026

Obesity
Phase 2 Virtual Meeting

Welcome

John W. Kennedy, MD, *President, AMGA Foundation, and Chief Medical Officer, AMGA, and* **Jim Gaither**, *Director, Health Systems Strategy, Novo Nordisk Inc.*

AMGA's Obesity Quality and Innovation Collective (QuIC) is a three-phase initiative designed to help healthcare organizations develop and implement a systematic approach to obesity care management.

In October 2025, participants gathered in two virtual sessions for Phase 1. Grouped into two tracks based on the maturity of their obesity programs, they talked about their top challenges and opportunities, with a focus on educating clinicians and staff, increasing access to services, and delivering multidisciplinary care.

Six months later, Kennedy and Gaither welcomed participants back as a full group for Phase 2, a two-day virtual event to share progress so far by their organizations and by the QuIC as a whole. Sessions also offered an opportunity to learn from peers and gain expert insight into research, approaches, and treatments, including "new innovations and what's to come in obesity care," in Gaither's words.

"We'll be exploring how the landscape of obesity care continues to evolve," Kennedy said.

Keynote: The Evolving Landscape of Obesity Care: Access, Equity, and the Next Generation of Treatment

Angela Fitch, MD, FACP, MFOMA, *Co-Founder and Chief Medical Officer, knownwell; Past President, Obesity Medicine Association; Board Member, Obesity Action Coalition*

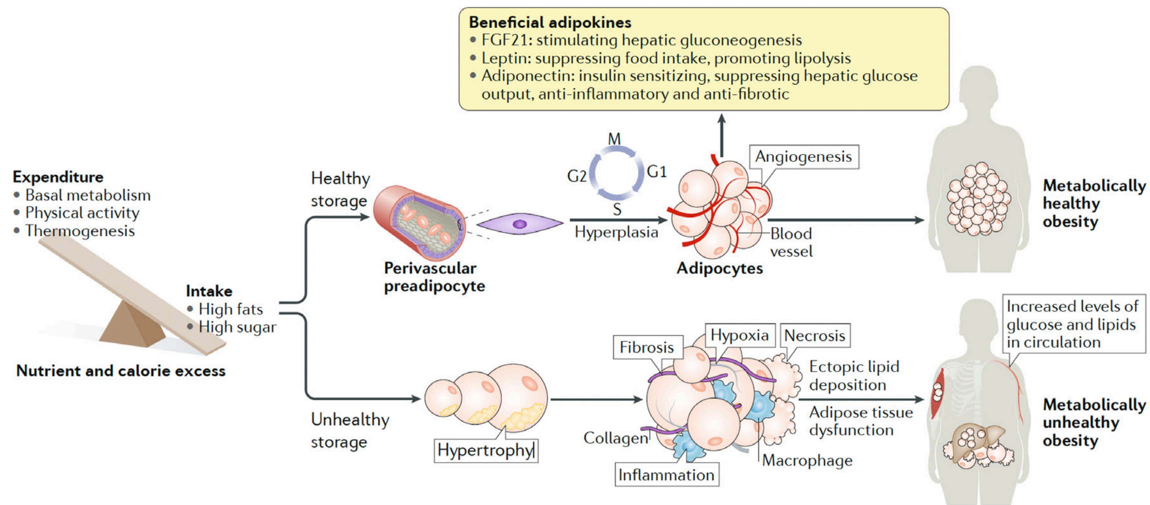
Moderator: **John W. Kennedy, MD**, *President, AMGA Foundation, and Chief Medical Officer, AMGA*

"Imagine a world where 50% of adults and 30% of children have a disease that makes all these diseases worse," Fitch began her presentation. Treatment exists that puts this disease in remission, but people say it's too expensive—that it wouldn't be necessary if patients just took care of themselves.

"That's what the world is like today for the disease of obesity," she declared.

She explaned how obesity is a chronic, treatable disease, rooted in the dysfunctional storage of excess energy.

OBESITY IS A DYSFUNCTIONAL STORAGE OF EXCESS ENERGY



Ghaben, A.L., Scherer, P.E. Adipogenesis and metabolic health. *Nat Rev Mol Cell Biol* **20**, 242–258 (2019).

Several genetic and situational factors impact a person's "set-point" weight: processed foods, irregular eating habits, inadequate sleep and physical activity, and increased stress, as well as medications that result in weight gain and life changes such as pregnancy, aging, and menopause.

Fitch called it "a perfect storm" that causes people to gain and regain weight. "This is biology—how we're engineered—and lifestyle alone isn't enough," she said. "We need procedures, surgery, and medications."

GLP-1s Expand the Treatment Ecosystem

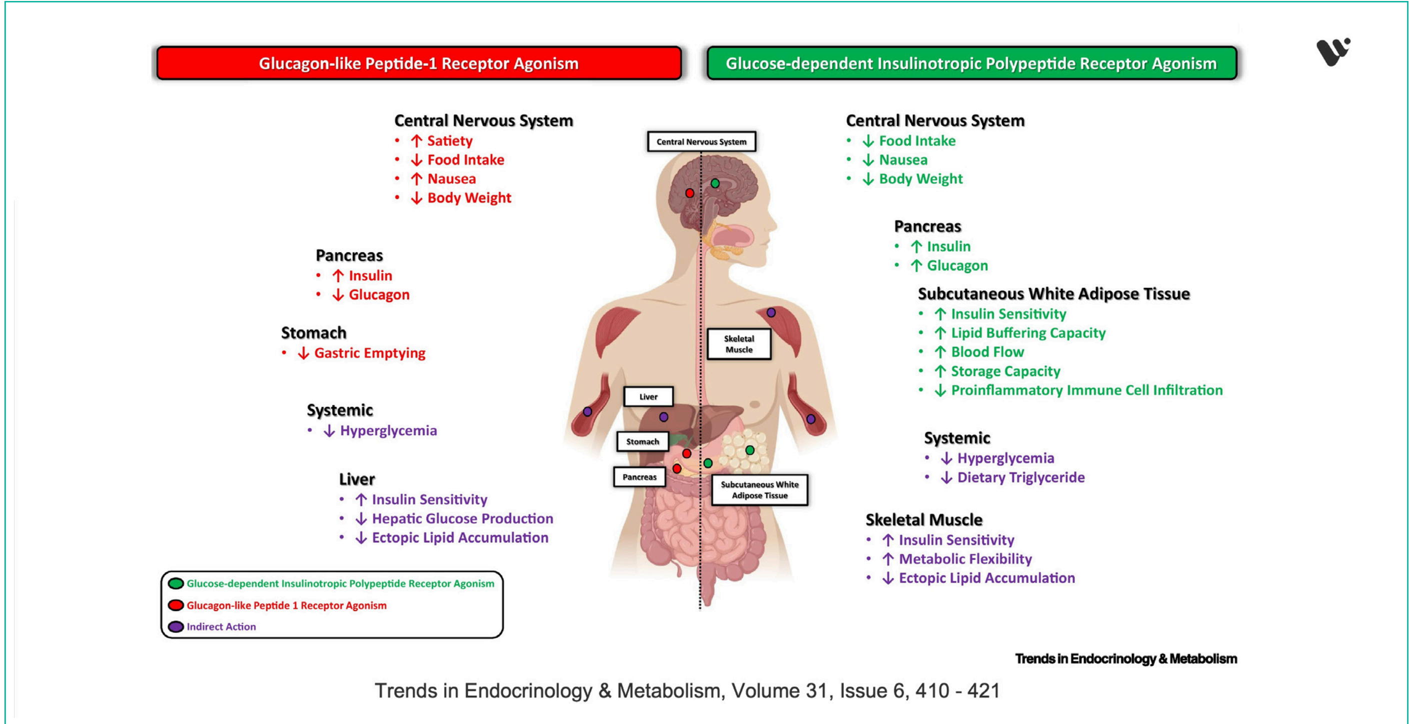
Fitch walked through the evolution of glucagon-like peptide (GLP-1) receptor agonists, from their roots in Gila monster saliva to their beneficial effects throughout the body, such as reduced inflammation to improved blood flow.

She shared weight loss data for oral and injectable doses semaglutide, which mimics the GLP-1 hormone, and tirzepatide, which mimics both GLP-1 and gastric inhibitory polypeptide (GIP).

Medications in the pipeline today are aiming for easier, longer-acting dosing and targeting a broader range of indications, such as sleep apnea, secondary cardiovascular disease, osteoarthritis, and metabolic-associated steatohepatitis (MASH).

"Losing 5% to 10% of body weight is beneficial to health," Fitch said. "But it's a struggle to get to 15% to 20%, where more diseases go into remission."

Another goal is preferential fat loss, so patients maintain muscle as they lose weight. "The goal is leaner, not just lighter."



Trends in Endocrinology & Metabolism, Volume 31, Issue 6, 410 - 421

Weight-Loss Responder Rates Across Semaglutide & Tirzepatide Trials

Weight loss threshold	Oral semaglutide 25 mg (OASIS 4)	Semaglutide 2.4 mg SC weekly (STEP 1)	Tirzepatide 5mg SC weekly	Tirzepatide 15 mg SC weekly (SURMOUNT -1)
≥5%	79%	86%	89%	96%
≥10%	63%	69%	79%	90%
≥15%	50%	50%	59%	78%
≥20%	30%	32%	32%	63%

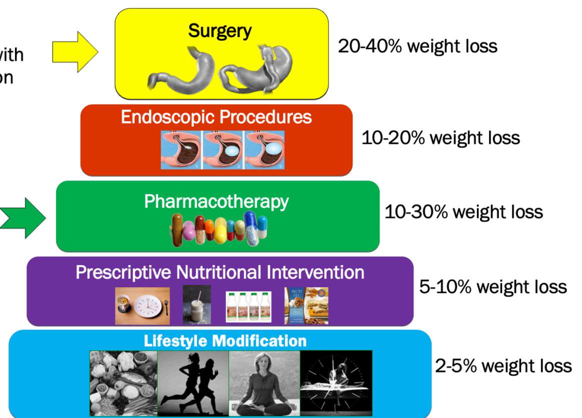
OTHER TREATMENT OPTIONS

- Once daily liraglutide GLP-1
- Meal replacement programs
- Bariatric surgery

Increasing health risks
Increasing adiposity

BMI > 35
BMI > 30 with complication

BMI > 30
BMI > 27 with complication



1. O'Neil PM, Birkenfield AL, McGowan B, et al. A randomized, phase II, placebo-and active-controlled dose-ranging study of semaglutide for treatment of obesity in subjects without diabetes. Presented at the 100th Annual Meeting of The Endocrine Society, Chicago, Illinois; March 18, 2018. Abstract OR12-5.
2. Lancet. 2011 Oct 22; 378(9801): 1485–1492.
3. JAMA Surg. 2016 Nov 1;151(11):1046-1055.
4. Obesity (Silver Spring). 2011 Jan; 19(1): 110–120.
5. Obesity (Silver Spring). 2019 Jan;27(1):75-86

Fitch also talked about developments in overall care delivery, like the shift from body mass index (BMI) to weight-to-height ratio as a way to measure progress and the move to more personalized care as more options enter the treatment ecosystem.

Medications, combined with lifestyle coaching, have become a vital part of obesity care, she concluded. But a significant barrier stands in the way: access.

Making Obesity Care a Standard Benefit

Right now in the United States, obesity care is considered an elective benefit, with only one out of five employers covering it in their benefits packages. "How do we get to standard coverage, like we have for cardiovascular disease?" Fitch asked.

While custom-mixed medications have emerged as a lower-priced way to access GLP-1s, "I don't think compounding should be the way out," she cautioned. "This is not an aspirin. It's a biological agent."

The federal government has been making progress through the Medicare GLP-1 Bridge, beginning July 2026 and extending through 2027, and BALANCE, a voluntary model in which the Centers for Medicare & Medicaid Services (CMS) will negotiate drug pricing and coverage terms with manufacturers of GLP-1 medications on behalf of state Medicaid agencies and Medicare Part D plan sponsors.

At the same time, groups like the Obesity Medicine Association have been advocating in areas like pre-authorization, legacy medications, digital health, and nutrition, as well as calling for the Treat and Reduce Obesity Act to become permanent legislation.

Fitch presented two potential scenarios in which obesity medication could cost patients mere dollars a day. “It doesn’t have to be all or nothing, as it is today, due to being elective benefit.”

She concluded with her vision of an ideal state of obesity care, one that would support patient experience, population health, provider work-life balance, and health equity, while reducing costs.

WHAT IF WE COULD TREAT EVERYONE?

$1.1 trillion in healthcare savings/yr treating 45 million of the 100 million adults with obesity!

Naltrexone/bupropion	Phentermine/topiramate
30% of patients able to get 15% weight loss.	15% of patients get 20% weight loss
$99/mo $3/day	Generic is $60/mo $2/day
30 million Americans with obesity who could achieve a 15% weight loss with $3/day treatment.	15 million Americans could achieve a 20% weight loss for $2/day
Cost = $1095/yr/pt or $32.8 billion	Cost = $730/year/pt or $10.9 billion
Estimated savings $1 trillion Net savings $67.5 billion	Estimated savings $50.1 billion Net savings $39.2 billion

Make obesity an essential health benefit that all payers must cover. Reduce bias and stigma in the identification and diagnosis of the condition. Offer medication treatment with lifestyle coaching, with no prior authorization required for lower cost medications or certain conditions.

“This would help us achieve the Quintuple Aim for all,” she said.

How do you help patients navigate key decision points, especially among the many options now available?

“In shared decision-making, it’s important to meet patient where they’re at,” Fitch said. “Get that history of what the patient has tried,” she advised, comparing weight loss challenges to struggles with smoking cessation. “Most people who come in seeking obesity treatment have tried lifestyle interventions seven or eight times.”

Then equip patients with data, including potential outcomes, when matching treatments to conditions and presenting options, she said, advising that care teams treat obesity-related risk with the same gravity as high blood pressure.

How do you help providers make the right choice for each patient?

In addition to considering side effects and contraindications, “we have to factor in cost, unfortunately,” Fitch said. She suggested starting treatment with less expensive or older medications first, then “escalating up as needed, as we’d do for a disease with standard coverage.”

What metrics do you use to demonstrate success to payers and senior leadership?

As metrics take shape for measuring more complex outcomes like reduced complications and improved quality of life, Fitch recommended using weight-height ratio to show progress toward weight loss goals or BMI to show a shift in risk—from Class 3 (severe risk with a BMI of 40+) to Class 1 (lower risk with a BMI of 30-34.9), for example.

Obesity QuIC Quality Improvement Report

Earlean Chambers, RN, MS, CPHQ, *Senior Director of Clinical and Quality, Population Health Initiatives, AMGA Foundation*

Chambers shared highlights from the assessments and reports that participants and the advisory committee submitted in advance of the meeting, reminding the audience that obesity programs at QuIC organizations are at varying stages of maturity. "We're all at different stages of journey, but everyone is moving in same direction."

She praised several collective strengths of the QuIC. Every organization has articulated a clear future state and has moved beyond single providers to multidisciplinary teams for obesity medicine. Furthermore, groups are pursuing or achieving certification and making strides in technology use, with a focus on Epic optimization, AI tools, and outcome tracking in areas such as individual patient weight loss and the improvement of comorbidities across a population.

> *"This group has done remarkable work, and what you see today is only the beginning."*
>
> **— Earlean Chambers, AMGA Foundation**

Chambers praised participants' shared focus on community engagement, from partnering with food pantries to reaching out to media to amplify their work. "There's a genuine investment in reaching patients beyond clinics," she observed.

In terms of obstacles, staffing and capacity were barriers "identified by virtually everyone," she said, along with reimbursement and access. Prior authentication bottlenecks and payer variability for obesity care "create real gaps."

High no-show rates complicate care management. In terms of access and care delivery, participating organizations struggle with geographic barriers, serving patients with complex needs, and scaling their activities, both virtual and in person. Rapid expansion often strains onboarding.

Specific to technology, most organizations collect data but lack infrastructure to generate actionable insights, Chambers said. Meanwhile, electronic health record (EHR) integration lags, with outcomes not consistently linked across teams.

Finally, the QuIC assessment found inconsistency across groups in resources such as internal champions and provider education.

With this overview as context, Chambers presented what QuIC participants are working on to strengthen education, access, care team capacity, reimbursement, technology, and more.

"Projects mirror maturity levels," Chambers noted. "Everyone works at their edge, and every project works toward a gap."

AMGA Quality and Innovation Collective (QuIC)

Obesity – *Phase 1 Virtual Meeting*

PROJECTS AT A GLANCE · 9 Organizations, 9 Interventions

Category	Organization	Intervention
Data & Measurement	**Allina Health**	Improve EPIC documentation to capture 5 comorbidities for post-bariatric surgery patients in Lifestyle AfterCare Program
Provider Education	**Christus Health**	Build standardized onboarding toolkit & resource library to support rapid clinic expansion and provider confidence
Pediatric Access	**Guthrie Medical Group**	Expand pediatric sports nutrition service to 10+ new patients; integrate into Guthrie Weight Loss Center at 2 sites
Care Team Capacity	**Hattiesburg Clinic**	Implement evidence-based lifestyle modification curriculum within Medicare/MA case management using motivational interviewing
Technology & Tools	**Kelsey-Seybold Clinic**	Launch DEXA scan pilot — reduce OOP cost by 60% to 70% opt-in rate for body composition screening at PathWeighs visits
Standardization	**Northwell Health**	Create SharePoint resource hub + EPIC templates, flowsheets, and note templates for EPIC Wave 1 weight mgmt providers
Program Development	**Sharp Community Medical Group**	Phase 0–6 month clinical pathway build for BMI>30/GLP-1 patients: governance, Epic build, provider training, pilot launch
Workforce & Reimbursement	**Sharp Rees-Stealy**	Create obesity medicine compensation model + secure APP hiring approval to enable scalable, financially aligned care delivery
Care Model Innovation	**Hackensack Meridian Health**	Virtual Shared Medical Appointment (vSMA) model: 6-month pilot combining individual physician visits + monthly MDT group sessions via Zoom

ASSESSMENT TO ACTION · How Projects Address Identified Gaps

ASSESSMENT GAP / NEED		PROJECT RESPONSE
Uneven provider education & rapid clinic growth	→	Christus Health: Standardized onboarding toolkit & resource library
Organizational silos & fragmented EHR tools	→	Northwell Health: SharePoint hub + EPIC templates for all sites
Financial barriers to physician recruitment	→	Sharp Rees-Stealy: Obesity medicine compensation model + APP hiring
Incomplete comorbidity outcomes tracking	→	Allina Health: EPIC data capture for 5 MBSAQIP comorbidities
Limited objective measurement beyond weight	→	Kelsey-Seybold Clinic: DEXA body composition pilot
Early-stage programs lacking structured pathways	→	Sharp Community Medical Group: Phased clinical pathway build with KPIs
Need for scalable virtual & group care models	→	Hackensack Meridian Health: Virtual SMA with MDT monthly sessions
Inconsistent team-based patient education	→	Hattiesburg Clinic: Case management lifestyle curriculum
Limited pediatric specialty access in rural areas	→	Guthrie Medical Group: Pediatric sports nutrition expansion to 2 sites

The QuIC's three themes—standardization and provider infrastructure; data, measurement, and technology; and care model innovation and access expansion—facilitate cross-organizational knowledge transfer and growth.

"Together, these projects tell a story," she concluded. "Where one organization is piloting, others can learn and eventually replicate."

Multidisciplinary Team Models and Care Coordination

Moderator: **John D. Clark, MD, PhD**, *Chief Population Health Officer, Sharp Rees-Stealy Medical Group*

Lifestyle Management and Shared Learnings at Allina Health

Allina Health presented on how their weight management program keeps patients engaged and care teams aligned across Minnesota and Western Wisconsin.

The journey to the program begins with a centralized appointment phone number/online presence and an automatically routing referral order in Allina Health's EMR.

Eligible patients receive a call or email from the program team within 48-72 business hours. "The primary care or other provider just sends us the patient, and we take it from there," the team noted, adding that this process generates more than 1,160 referrals a month and that roughly 33% of referred patients schedule a consultation within 60 days.

Program participation includes a visit with a dietician and a referral to physical therapy with the Courage Kenny Rehabilitation Institute. "Many times, patients with obesity don't know where to get started with activity," the Allina Health presenter said.

Patients managing their obesity with medication receive education about bariatric surgery every six months if they are eligible, and Allina Health's Lifestyle Aftercare Program keeps patients engaged after the procedure, with a focus on sleep, nutrition, social connection, mental health, and more—"all of the factors that influence someone's weight," the presenter said.

For patients with more complex conditions, multidisciplinary rounds keep care team members up to date and aligned in areas such as eating disorders, mental health, and social drivers of health/resource issues like housing insecurity.

Opportunities for shared learning are vital in a rapidly evolving field like obesity medicine, Allina Health emphasized. To this end, the weight management program hosts monthly meetings for primary care and weight loss providers along with biannual educational sessions that bring in knowledge from dietitians and nurses, "so everybody knows strategy and how we're moving forward and so we maintain a consistent experience for patients across sites," the presenter said.

Integration and Flow at the Guthrie Weight Loss Center

Representatives from the Guthrie Weight Loss Center talked about how the Guthrie Weight Loss Center delivers obesity care to the Guthrie Clinic's patients in New York and Pennsylvania.

One key component is maximizing the scope of a multidisciplinary team, from providers to front office staff like surgical schedulers and an insurance verification specialist. The other part is process, specifically a coordinated continuum of

early identification, comprehensive management, and longitudinal maintenance.

"We wanted to design an efficient patient flow model," the Guthrie Weight Loss Center team said.

This model starts with a referral to the Weight Loss Center by primary care providers who are educated about obesity as a chronic disease. Early diagnosis of obesity is a system strategy at Guthrie Clinic, the team noted, with obesity care strategically integrated throughout the organization.

Comprehensive care management, the next steps, brings in nutrition, behavior, and surgical specialists from the Weight Loss Center, supplemented with pharmaceutical management when appropriate. As needed, the center refers patients to specialties like cardiology and sleep medicine across Guthrie Clinic's network.

Finally, the Weight Loss Center serves as a central hub for longitudinal maintenance, including regular visits and check-ins for surgery patients and patients taking medication. The center works with primary care and specialties to manage comorbidities.

"How do we all keep integrated as one? We all function very closely," said a Guthrie Weight Loss Center presenter.

"Shared visibility within the EMR really helps," said another Guthrie Weight Loss Center presenter.

Getting More Children into Treatment Earlier

Pediatric patients are an important part of the Guthrie Weight Loss Center's work. "We were seeing really sick kids, with 50 to 100 excess pounds of fat, hypertension, fatty livers," the team recalled. "What was the delay in diagnosis?"

The Guthrie Weight Loss Center team discovered that providers weren't comfortable having obesity-related conversations with parents. "Parents see it as a personal attack."

In response, the Guthrie Weight Loss Center launched a concentrated effort to identify eligible young patients earlier. This included speaking at Grand Rounds to educate primary care and pediatric offices diagnosis criteria, documentation, and their important role in the treatment process.

"We're really focusing on the fact that obesity is a disease," the team said.

Results have been encouraging so far, according to Guthrie Weight Loss Center. In the span of just a year, pediatric obesity diagnoses, referrals, and clinic visits have all increased.

To keep the Weight Loss Center aligned in patient care and with new developments in obesity management, "we're always looking at how we can improve," the Guthrie Weight Loss Center team said. The team facilitates knowledge-sharing through meetings with leadership, monthly educational presentations, and multidisciplinary gatherings of medical and surgical teams.

"As things change with new research and ways of doing things, we want staff to be educated," the team said. "We pride ourselves on being evidence-based, and care needs to be consistent across the board."

Hattiesburg Clinic's Education and Collaboration in Action

Hattiesburg Clinic presenters talked about how education and collaboration are delivering obesity care to Hattiesburg Clinic's patients across the southeastern United States.

Full-time nurses are the engine powering case management. Embedded directly within primary clinics, they interact with patients each month to review charts, coordinate care for chronic diseases, and keep patients engaged. Such

engagement includes practical nutrition guidance and SMART (specific, measurable, achievable, realistic, and measurable) goals for more sustainable weight losses.

Nurses and providers receive monthly education from specialists like dieticians to build their skills and knowledge for patient conversations. As a result, they are able to more effectively engage patients in collaborative goal-setting and sustainable lifestyle changes.

“We've really put a lot of focus on motivational interviewing,” one presenter said. Another noted that real-world scenarios shared in these sessions have contributed to “a real increase in comfort and competence.”

Well-orchestrated processes keep care delivery on track.

Primary care providers, case managers, and specialty providers collaborate on patient care plans. Structured workflows ensure that patients have a coordinated pathway to behavioral health services, nutrition education, and other obesity-focused support.

Given the program's focused management of chronic conditions like hypertension, diabetes, chronic kidney disease, gastroesophageal reflux disease (GERD), and atherosclerotic cardiovascular disease (ASCVD), the need for efficient coordination extends beyond Hattiesburg Clinic itself.

“Our patients are seeking care in other settings,” the Hattiesburg Clinic team said. “We need to keep everyone on the same page in achieving outcomes.”

Hattiesburg Clinic emphasized to their fellow QuIC members that knowledge is power, recommending focused training in both patient engagement (problem-solving, self-monitoring, accountability, addressing bias and stigma) and areas such as nutrition, physical activity, and sleep, stress, and pain management.

“Leverage your SMEs [subject matter experts],” a Hattiesburg Clinic presenter said, explaining that education extends upward as well. “Help your clinic leadership understand the why behind obesity care: the need for it, its importance, and how it ties into value-based care and the mission of healthcare.”

Another lesson learned: “Get a physician champion,” the Hattiesburg Clinic team said. “Ours has been instrumental in guiding us and helping us build our program.”

Which skills and specialties have been most critical to growing your programs?

At Allina Health, a mental health provider was the next logical addition to its core weight loss team of surgeons and dietitians. The Allina Health presenter noted that some of these specialists had expressed an interest in obesity management—but getting them on board was easier said than done.

“We fought long and hard to get mental health on the surgical side,” the Allina Health presenter said. “There's such a shortage right now.”

More broadly, Allina Health suggested bringing in nurse practitioners, physicians assistants, and advanced practice clinicians for tasks they could accomplish more cost-efficiently than physicians, making the business case for these hires by showing the potential ROI to executive leadership.

“Sell obesity management to leadership as a profitable program and connect it to overall health and wellness,” she advised.

Guthrie Weight Loss Center encouraged this approach: "You're trying to prove what your needs are and add people who can practice at the top of their abilities."

Similar to Allina Health, the Guthrie Weight Loss Center started its efforts with surgical services, supported by dieticians and psychology. Medications were a logical next step, and a physician specializing in obesity medicine proved "the driving force for getting the program to grow." The Guthrie Weight Loss Center presenter said.

She underscored the importance of leadership buy-in, along with systemwide support, for program growth. "The organization has to want it, too."

Talk about your experiences with shared medical appointments and group meetings.

The Guthrie Weight Loss Center did "a fair amount" of these during COVID, supported by an Epic build for virtual meetings. "If done well, it can be a great resource."

But success is not guaranteed. "You definitely need a facilitator and a common thread, to make sure the group is moving along efficiently," the Guthrie Weight Loss Center presenter said. "And you really need to know who you're putting into that group; one person can easily make or break it."

Allina Health has explored—but not yet embraced—group visits for obesity care. "Reimbursement is challenging due to the time involved in setup and finding a time of day that works for everybody," the Allina Health presenter said. "You don't get a lot of bang for your buck."

What role has primary care played in your programs as they've grown?

At the Guthrie Weight Loss Center, primary care doctors have been a longtime referral source. "We've gone out to their offices in the past and have a really good relationship," the Guthrie team said. The challenge now is ensuring patient access as demand increases, especially with the Guthrie Clinic's own employees required to seek obesity care through the weight loss center.

Allina Health is also navigating challenges related to referrals and access. "We tend to get patients without medical coverage, and primary care sends them our way," the Allina Health team said.

To accommodate rising demand, Allina Health has been building capacity outside of its program and primary care. Potential solutions include expanding obesity management into preventative cardiology (Allina Health is currently putting together a business case for this) and partnering with the organization's GI practice, so patients receiving GLP-1 prescriptions for conditions like MASH get the full continuum of support.

Hattiesburg Clinic likened team coordination for obesity management to how the organization delivers care for diabetes and cardiovascular conditions, with everyone having a role to play, regular department and manager meetings to level-set, and quality improvement factored in throughout.

"I think that has really helped build engagement with primary care physicians," the Hattiesburg Clinic team said.

As mentioned earlier in the session, well-defined processes have been key to success, with the specifics of these structured pathways guided by areas of demand and services for which the organization can receive reimbursement.

Helping Patients Succeed: Improving Motivation and Long-Term Engagement

Lydia Alexander, MD, MFOMA DABOM, DABLM, *Chief Medical Officer, Enara Health, Immediate Past President, Obesity Medicine Association*

"Understanding the past, present, and future helps our patients succeed," Alexander said to establish the context of her presentation.

"Very myopically, we only looked at obesity through the lens of weight loss," she recalled. As patients sought a "magic diet," they—and their healthcare providers—internalized the message that obesity management is all about self-help. "If you cared about it enough, you could do it alone."

These preconceptions resulted in a very weight-centric approach, according to Alexander, with all parties frustrated by a lack of lasting results.

> *"It's important to diagnose and discuss obesity with dignity with patients, reinforced with training and services across the full continuum of care."*
>
> **— Lydia Alexander, Enara Health**

GLP-1s, and the research behind them, brought fresh thinking. "We now know that biology regulates weight, and it's shifting the thought process around bias and stigma," Alexander said.

The next necessary step, she explained, is to reframe obesity management as a lifetime continuum of care, with touchpoints throughout and progress linked to better health and functional outcomes.

Research supports a long-term, continuous approach to obesity management, Alexander said, sharing a study spanning five years across a large healthcare system. "Patients were very motivated. They showed up. They did the work. Yet most of the weight returned in year two or three."

Success also requires "the correct ecosystem in a compassionate environment," she added, and one key pillar of such an ecosystem is motivational interviewing: a collaborative, goal-oriented communication style that focuses on the language of change.[i]

Alexander walked through how providers can guide patient conversations toward sustainable progress.

"What would better health let you do that you aren't able to do today?" For a patient in obesity care, the answer might be walking without pain or playing with children or grandchildren.

"Use patient-first language. It costs nothing and saves everything," Alexander advised. Reframe success, with weight loss part of the picture only if the patient wants it.

Aim for early wins, with one or two goals set at the appointment itself, and emphasize self-efficacy from the start. Alexander suggested manageable changes in behavior that patients can realistically incorporate into daily life, such as one serving of protein added to breakfast or a 10-minute walk after meals.

"High motivation isn't required if the plan is low friction," she noted.

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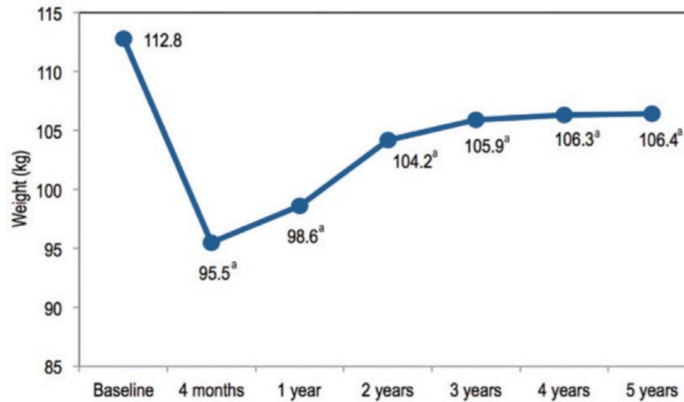
[i] Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). New York, NY: Guilford Press

KAISER TRANSFORM MEDICAL WEIGHT MANAGEMENT PROGRAM RESULTS

Real-World Effectiveness of a Medically Supervised Weight Management Program in a Large Integrated Health Care Delivery System: Five-Year Outcomes



Krishnaswami A, Ashok R, Sidney S, Okimura M, Kramer B, Hogan L, Sorel M, Pruitt S, Smith W. Real-World Effectiveness of a Medically Supervised Weight Management Program in a Large Integrated Health Care Delivery System: Five-Year Outcomes. Perm J. 2018;22:17-082.

Start with "why" and make goals patient-defined

Motivation sticks when it's tied to identity and function, not just a number.

- Ask: "What would better health let you do that you can't do right now?"
- Convert to **2–3 functional outcomes** (walk without pain, play with kids, sleep, energy, labs) + **one weight-related goal** if they want it.
- Reframe success: **health markers + function + behaviors**, not only weight.

1. Ask the Right Question

"What would better health let you do that you can't do right now?"

2. Convert to Functional Outcomes

Convert to **2–3 functional outcomes** (e.g., walk without pain, play with kids, sleep, energy, labs) + *one weight-related goal* if they want it.

3. Reframe Success

Reframe success: **health markers + function + behaviors**, not only weight.

Maintain momentum by prioritizing action, even if activities are incomplete or imperfect. "A predictable follow-up rhythm matters more," Alexander said.

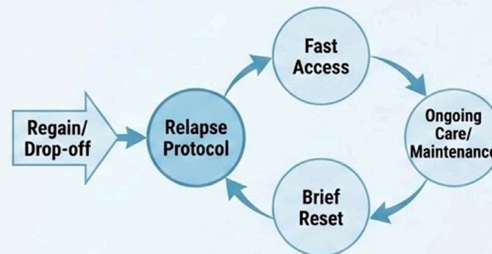
Barriers and/or disengagement will happen, she warned. Treat these incidences as clinical data, not noncompliance. Examine the reasons why, which might involve shame, trauma, and time scarcity.

Then revisit and revise the patient plan accordingly, accommodating for lapses "because life is messy." Encourage patients to build social support "that doesn't shame."

Use a relapse protocol (so patients don't disappear)

Have a scripted plan for regain or drop-off:

1. "If weight is up 3–5% or cravings return, we do X."
2. Fast appointment access
3. Brief reset: sleep, protein, steps, stress, med check, barriers



This turns relapse into a **routine clinical event**, not a personal failure.

This turns relapse into a **routine clinical event**, not a personal failure.

"Without motivational tools, engagement, and a support plan, we can't expect results," Alexander summarized.

For teams providing obesity care, she emphasized the importance of consistent messaging that obesity is a disease, as bias and stigma cause patients to drop out of care.

"Internalize that messaging," she said. For care that involves GLP-1s, "treat the biology," she advised, "so medications don't feel like crutches or extras. The patient sees that they make treatment possible."

Finally, back up encouraging conversations and words with access to the appropriate resources. "Make sure you have a process that works for lasting outcomes and improved quality of life, one that's effective and judicious in medications and costs," Alexander said, pointing out that healthcare organizations can outsource these resources or offer them as wraparound services.

Throughout, normalize "maintenance mode," that obesity management is a long-term, ongoing journey.

"Set this expectation early, just as you would in treatment for hypertension or type 2 diabetes," Alexander said. "It's truly one of the most important aspects to success."

Solution Room Breakout: Track 1

Moderator: **Lydia Alexander, MD, DABOM, DABLM, MFOMA**, *Chief Medical Officer, Enara Health & President, Obesity Medicine Association*

In this breakout session for organizations with obesity programs at a more advanced stage of maturity, participants shared their challenges, questions, advice, and visions for the future.

Expansion to meet demand was a common theme. One group talked about acquiring a facility with established surgical and medication providers. Another brought up the challenges of adding pediatrics and different program lines. "We've paved the way, but how do we make onboarding, clinic setups, and finding physician champions easier?"

Participants also talked about care delivery, with one moving toward the use of full-time obesity medical providers with advanced practice providers (APPs) for support. Other participants cited reimbursement issues and "a lot of pushback and resistance" specific to this role. "Some providers are not used to APPs. It feels dangerous from a liability standpoint," was one observation. "It's a paradigm shift, but it's a direction we need to go," another participant countered, adding their view that APPs on the care team have "worked really well" in some regions and states.

As demand for obesity care grows, access to care remains a persistent challenge. Adding staff isn't always the answer, participants concurred, due to hiring challenges, facility space limitations, and state limits for certain roles.

Another area many groups are tackling instead are prior authorizations, from the surges in paperwork as more medications enter routine care to the bottlenecks when coverage for these pharmaceuticals is disputed or denied.

One organization is hosting a monthly lecture series for primary care providers about the latest developments in obesity medications and coverage, "so we don't overload systems with those unlikely to get approved." At another, pharmacy employees have been sharing their observations on what gets approved and denied by various insurance plans and for specific indications.

"Cut down on the number of prescriptions where obesity is the only diagnosis," one participant advised. "These tend to get rejected." Other programs are engaging patients in this battle, asking them to use online tools or check with their plan about coverage and even equipping them with templated letters for making a case for coverage with their employers.

Finally, strict prescribing criteria, strictly enforced, can ward off pharmacy-related bottlenecks before they happen. "We don't order medications that we know won't be covered," one participant declared.

Once a prescription for obesity care is approved, regular visits afterward, often mandated as a condition for coverage, present another challenge.

"Our biggest insurance carrier said patients have to be seen every month," one participant said. One potential solution, telehealth, only partially addresses this challenge because virtual appointments still take up room on a provider's schedule. Moreover, technology doesn't always increase engagement. "We have tried sending patients to an app after one visit with the physician," one participant shared. "Patients don't love it."

Other groups have been revisiting roles and responsibilities. In one organization, this involves offloading nutrition-related follow-up to dietitians, with medical assistants handling the data-tracking and a strict no-show policy mitigating the waste and work involved when a patient misses an appointment.

"We've tried to be creative as much as possible," another participant said, describing how their organization has enlisted pharmacists and EMR tools for check-ins and documentation and is considering a care path/companion module to both educate patients and meet follow-up requirements.

AMGA Obesity QuIC Trac 1 Participants

- Alina Health
- CHRISTUS Trinity Clinic
- Guthrie Medical Group
- Sharp Rees-Stealy Medical Group
- St. Luke's Physician Group

The conversation also touched on group visits, with one model putting a physician's assistant in the lead role with specialists in obesity medicine, psychology, bariatric surgery, and medicines lending their expertise. "They're cost-effective and a way to decrease wait list times." Participants noted how such group visits could tackle a variety of topics, from stress and insomnia to understanding medications.

Throughout these discussions of pre-authorizations and patient meetings, participants called out the importance of standardization. "How can patients have a similar experience wherever they go?" asked a participant exploring franchising as a way to serve its organization's rural patients.

Suggestions covered an array of tools and tactics, from regular meetings among team members to SmartPhrases and note templates in the EMR, even automated documentation via an AI solution like DAX CoPilot.

"You want to standardize if variability is creeping in," one participant emphasized. "It creates a culture of collegiality," was another observation.

Solution Room Breakout: Track 2

Moderator: **Verlyn Warrington, MD, MS, FOMA**, *Obesity Medicine Specialist at Guthrie Clinic and Professor, Family Medicine, Geisinger Commonwealth School of Medicine*

Participants with obesity programs at an earlier stage of maturity shared their progress to date, pressing challenges, and questions.

How often should obesity care patients check in with a provider during the long-term maintenance phase, for example? "We see patients six times in the first twelve months, then quarterly after that," was one response. "We do once every one to two months, then extend that as they level out, with six months being the max," was another.

Participants also sought on-the-ground insights about shared medical appointments. "We're planning for in-person sessions to start, but we'll eventually offer virtual options to give more people access."

"In our clinic, we do group education for behavior management," one participant shared. "We see between four and 20 people in a one- to two-hour session, in a classroom and virtually. It's been very effective so far." Another suggestion: Pick a theme beyond weight loss, such as uncontrolled diabetes or exercise challenges, with smaller (six people max) group sizes.

AMGA Quality and Innovation Collective (QuIC)

Obesity – *Phase 1 Virtual Meeting*

How does an obesity program get eligible patients into the system in the first place? Technology is one solution. “You can flag patients in Epic, with a trigger that shows when a patient is enrolled in the obesity program,” suggested one participant. “We use a color-coded system to identify which patients get which focus. Doctors quickly see who is enrolled in what program. When you see a certain color flag, you have to check for specific things.”

Education is another. Members of the group encouraged building relationships with doctors—going to practices to talk about their programs, typical patients, and the delivery of care for both obesity and comorbidities. Grand rounds and lunch and learn sessions, in person and online, can be a great way to reach many people at once, with shadowing, fellowships, and student electives excellent channels for building the next generation of knowledge.

AMGA Obesity QuIC Trac 2 Participants

- Hackensack Meridian Health Medical Group
- Hattiesburg Clinic
- Kelsey-Seybold Clinic
- Northwell Health
- Sharp Community Medical Group

Participants discussed the importance of standardization. “We don’t always know what other practitioners are doing,” one remarked. Online platforms, especially familiar ones used systemwide, can be a convenient way to save and share documentation. “Teams is a lifesaver for getting everyone on the same page and instantly communicating any changes,” was one suggestion.

“Start small,” was one piece of implementation. “Get a few practices working together to use the same template, intake questions, and metrics, and build from there.” Work groups that develop consensus around key components, such as medication protocols, can be helpful with the human element of this work. “What really gives you the momentum is building relationships.”

Connections are key to growing a program, the group agreed. “Start with one or two clinicians,” recommended one participant, noting that it’s easier to ask a small group for time compared with “a whole building.”

Share what your program offers that makes it unique, along with how obesity medicine complements care throughout the enterprise. “Remind leaders of the big picture, like how lowering BMI can make more people eligible for hip and joint replacements. Make your work congruent with what the organization wants.”

“Track what you’re doing,” was another piece of advice. “Cultivate a relationship with an IT person who can run reports and pull data. When you need more resources and support, your ability to provide hard data is vital.”

As throughout the QuIC discussions, primary care factored in prominently throughout. “Think of how you can involve your primary care base, so you have more people to recruit,” one participant said. “Think about how you can teach primary care physicians to focus on metrics. Your programs will grow, and you will not lack for patients.”

Finally, participants recommended partnerships with mental health, nutrition, and exercise professionals. “Build a broad community so you’re not on the hook for every aspect of your program.”

Next Steps

Danielle Casanova, MBA, *Vice President, Population Health Initiatives and Health Equity, AMGA*

"These conversations are an important part of the QuIC program and help us all learn from each other," Casanova said as she thanked participants and concluded the Phase 2 virtual event.

She encouraged attendees to complete a participant survey and suggest topics for a June webinar. She also highlighted the third and final gathering of the QuIC, a virtual meeting in August to share best practices and lessons learned from their implementation plans along with next steps for delivering comprehensive, sustainable obesity care across their organizations.

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