AMGA™

Obesity

Quality and Innovation Collective (QuIC)

Phase 1 Meeting Summary | October 14 & 16, 2025

Obesity – *Phase 1 Virtual Meeting*

Phase 1 Virtual Meeting

AMGA's Obesity Quality and Innovation Collective (QuIC) is a three-phase initiative, designed to help healthcare organizations develop and implement a systemic approach to obesity care management. Through virtual discussions, interactive workshops, and quality improvement tools, participating organizations will collaborate to identify effective strategies and interventions for optimizing obesity care.

The QuIC combines a virtual discussion forum and virtual meetings with structured workshops to facilitate meaningful dialogue among AMGA member organizations. By leveraging qualitative methodology and best practices, participants explore ways to enhance, implement, or refine their obesity management programs.

For Phase 1 of the QuIC, participants met virtually for 90 minutes on two days (Oct. 14 and Oct. 16, 2025), grouped in two tracks based on the maturity of their obesity programs. To guide these discussions, participants completed a detailed survey before the meeting, ranking the top challenges and barriers to obesity management in their organizations.

Both Track 1 (healthcare organizations (HCOs) with a systemwide advanced obesity management program) and Track 2 (those with a less advanced program across their organization) ranked clinician and staff education as their top motivating need.

The next two top-ranking motivations were increasing access to care and delivering multidisciplinary care, with care access ranking higher for Track 2 organizations and multidisciplinary care delivery ranking higher for Track 1.

AMGA Obesity QuIC Participants

Track 1

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

Track 2

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

Important Work

The advisory committee of the QuIC welcomed participants to the Phase 1 meeting with encouraging words.

"This is extremely important work." said John Clark, MD, PhD, chief population health officer for Sharp Rees-Stealy Medical Centers, calling it "life-changing treatment," saying, "Treating obesity is not only important for patient health; it's a unique opportunity to engage with patients in a way that's different from other work we do in healthcare."

Yet the HCOs providing care are too often challenged to keep their "head above water," in the words of Verlyn Warrington, MD, MS, FOMA. As director of obesity medicine at Guthrie Clinic and professor of family medicine at the Geisinger Commonwealth School of Medicine, Warrington talked about her own organization's challenges recruiting primary care providers to a "very busy, very rural practice."

"How does your health system currently address comprehensive obesity care with your patients? How have you been doing it?" Lydia Alexander, MD, DABOM, DABLM, MFOMA, chief medical officer at Enara Health and president of the Obesity Medicine Association, asked participants representing HCOs from across the United States: California, Michigan, Minnesota, Mississippi, New Jersey, New York, Pennsylvania, and Texas.

Through the Obesity QuIC, participants will answer the following questions:

- What strategies can help them increase formal diagnoses for people with obesity?
- In a multifaceted field that includes counseling, nutrition, and medical and surgical interventions, how can they support these patients with evidence-based comprehensive care?
- How can their teams educate and support patients and care teams on the journey toward long-term, sustainable outcomes?

"Obesity is a chronic relapsing disease but isn't often treated like one," said Corey O'Brien, PharmD, medical account associate director with Novo Nordisk, sponsor of the QuIC.

With GLP-1 medications expanding options for and awareness of obesity medicine, "it's an exciting time to be in the field of weight management," one participant declared. Jim Gaither, director of health system strategy with Novo Nordisk, echoed this sentiment, calling the Obesity QuIC is "a very, very timely effort for a number of different reasons. Access has greatly increased, along with affordability in general."

Both Track 1 and Track 2 participants called out cost barriers in their write-in survey responses. These included insurance coverage and authorizations, as well as broader socioeconomic issues such as access to healthy food, food insecurity, and health equity overall.

Danielle Casanova, MBA, vice president of population health initiatives and health equity for AMGA, launched Phase 1 discussions with a synopsis of the mission: "to discuss the development of obesity programs in your organization, including strategies you're implementing currently or planning, and identify gaps and opportunities for future work."

The Top 3 Challenges and Opportunities

Participants shared many challenges they are facing.

"The past year has been ever-changing," remarked one participant, with another observing that "all the new things coming up" bring complications as well, such as "getting the meds covered" and "connecting with other specialties."

"How do we meet patients where they are with limited access and resources?"

In both Phase 1 sessions, discussions dove deeper into the three motivating needs: clinical and staff education, increasing access to care, and delivering multidisciplinary care.

In the multifaceted, rapidly evolving field of obesity management, HCOs are challenged to bring all the disciplines and services together, ensure capacity across a lifetime continuum of care, and keep patients and care teams informed, in an accurate, timely fashion, throughout.

Clinical and Staff Education

Especially with GLP-1 treatments rising in the media spotlight and everyday conversation, participants observed more data than ever about obesity and weight management. But all of this information doesn't necessarily translate to understanding.

Many noted seeing patients and providers alike who were overwhelmed, incompletely informed, and occasionally misled. "There is so much misinformation," one participant declared. "It's really troubling," said another, citing "this distrust" that emerges between patients and providers.

Groups prioritized "getting all team members on the same page" to give patients what they need, from sharing the latest developments to having conversations about options and potential outcomes. But this gets complicated when the field of obesity management—including what works and why—is evolving in real time.

"How do you explain 'this might be a good choice for you,' when there hasn't always been solid data for consultations?" one participant wondered. And how do you explain to a patient that bariatric surgery might not be right path for them now, but it could be worth considering in the future depending on how their condition progresses?

One HCO is working on a predictive model to share with its primary care providers for such shared decision-making, explaining that "the data speaks." This tool will display the percentage of weight loss possible with GLP-1s, bariatric surgery, and lifestyle modifications.

Such dashboards are only one aspect of a comprehensive knowledge base. "Many primary care physicians want to prescribe GLP-1s but don't understand the principles of obesity medicine," said one participant.

"How do you get people to make this a habit, to understand the importance of this initial conversation addressing obesity and overweight, so they start thinking about it early in the course of care and lifespan?" was another challenge that entered the discussion. "If you don't diagnose it, you don't treat it."

Capacity challenges and engaging all care team members effectively highlight the need for obesity education.

"If you want to expand the care team beyond specialists, you have to empower them with knowledge," one participant declared.

"Every practice is different, wherever that practice might be. Some are incredibly sophisticated. Others need a lot more help."

Groups shared their experiences. One HCO's weight management center empowers primary care providers to manage patients with pre-obesity and less severe conditions, allowing the center to focus on patients requiring more intensive care.

With obesity touching so many adjacent areas—such as endocrinology, cardiology, GI, orthopedics, and beyond—participants cited the importance of education throughout the care ecosystem. "We get a fair number of referrals from specialists, but we don't have a solid communications system for educating them," one said.

This knowledge-sharing includes letting people know what's available for obesity management within the HCO itself. "After 10 years of doing this, people still don't understand we even have our own program," one participant said.

Increasing Access to Services

Participants have been integrating obesity management into primary care operations and shared decision-making. One HCO requires a note in the electronic medical record (EMR) chart of any patient with a body mass index (BMI) over 30, for example, "which incentivized discussions on BMI."

When these discussions led to action, however, "we got more referrals than we could manage," a representative from the organization reported.

At one QuIC HCO, a "very inspiring" weight management clinic has a highly effective multidisciplinary team, top patient satisfaction scores—and a big problem. "We don't have capacity to send everyone to the clinic."

Participants cited "capacity as a barrier" throughout the care lifecycle. At one HCO, the lead time to see a specialist is 38 days. "You have to limit consults per day." At others, bottlenecks happen in primary care, which tackles everything from ongoing monitoring to prescribing and adjusting GLP-1 prescriptions. "Primary care physicians are the workhorses of our system."

Participants shared the different ways they're offloading providers' workloads and extending the care team's reach. One organization has "a very structured protocol" for GLP-1s. After a provider signs off on the prescription, an RN checks in with the patient, titrates the dosage as needed, and oversees automatic refills. "If there are any side effects, the RN lets us know."

Participants are also using remote patient monitoring to efficiently keep tabs on patient weight and body composition.

Yet successful weight management often requires a human touch. For lifestyle aftercare at one HCO, many patients "want accountability and a meeting," said a participant from the organization. The team found a solution within Epic: SmartPhrases that facilitate a move from frequent provider visits into a maintenance program.

But organizations in obesity management can't become too hands-off in their care. Insurance coverage for many GLP-1s requires a doctor's visit and medical documentation.

Virtual visits within Epic are one way to adapt, "especially for patients on medications who are doing well but need visits for insurance."

Group visits are another. "If you have six to eight people in a shared visit, you can tick off what's needed quickly," was one piece of advice. The secret, said another participant, is "having a good curriculum and delivering it efficiently."

Participants pointed out that "shared medical appointments don't reimburse well." One suggestion for getting around this: bundled packages for GLP-1 visits and services, similar to what obstetrics departments offer in the first trimester of pregnancy.

Delivering Multidisciplinary Care

Whether delivered in specialized bundles or across the lifecycle of a patient's journey, obesity management is multifaceted, involving not only medications and surgical interventions but the food a patient eats, their mental health, other health conditions, and their daily activities, including exercise. How do you deliver this care in a comprehensive, coordinated fashion across patients, practices, and the long-term continuum of this condition?

Many participants said they're guided by the pillars of obesity medicine: nutrition therapy, physical activity, behavioral modification, and medical interventions. They shared examples of these pillars in action.

At one HCO, an initial patient meeting includes a visit with a dietician at the same time. When patients achieve 5% weight loss, they receive referrals for strength training and mental health. Other areas of support include out-of-network care for eating disorders and lifestyle aftercare for bariatric patients, to manage for the possibility of weight gain in the years after surgery.

Another participant shared how a patient's first visit includes exercise and community resources. Doctors connect patients to local gyms owned by the HCO's parent organization, which will offer reduced pricing with a free evaluation.

This is all part of a "recipe card of recommendations" for medications and lifestyle interventions, a representative from the organization explained. "We look at behavioral health, sleep medicine, getting a nutritionist for more dedicated support."

How do you integrate it all without overwhelming patients or providers? One HCO is alternating various pillars throughout the patient lifecycle. "One month it's a dietician, one month someone else," a representative from the organization explained, calling out the value of crosstalk for bringing the pieces together.

"The key is to have everyone under the same umbrella," one participant suggested. "We deliberately work to present ourselves as a single entity," said another. "From a 2-year-old to a 90-year-old, whatever you need, we probably have an option for you."

On the backend, discussions highlighted the value of standardization and coordination. One HCO noted that "the right hand might not know what the left hand is doing," using its standalone obesity programs and those integrated with specialties (GI, primary care, bariatric surgery, cardiology) as an example.

Zoom out even more, operationally, and you have a multispecialty HCO with all employed physicians, delivering high-value care under a capitated model. "We're trying to tie it all together and make it appealing and eliminate barriers for patients, including cost."

Ensuring a steady pipeline of knowledgeable talent is critical to program sustainability and ongoing patient support. To this end, HCOs have started requiring obesity medicine rotations in family medicine and establishing obesity management residencies in areas such as endocrinology and pharmacy.

Conclusion and Next Steps

"I think we're going in the right direction to find the right fit for our organizations," Clark observed as discussions wrapped up. "This is just the beginning of a lot more practice-sharing and learning," Casanova concluded.

The Phase 1 meeting concluded with a review of the top three areas of focus: clinic staff and patient education, improving access, and multidisciplinary team care. These priorities will help guide participating organizations as they move into Phase 2, continuing to refine strategies and strengthen comprehensive obesity care across their systems.

About AMGA Foundation Quality and Innovation Collectives (QuICs) and the Obesity QuIC

AMGA QuICs utilize quality improvement tools and qualitative methodology to engage AMGA member organizations in order to prompt thoughtful discussions, collect insights, share best practices, and create opportunities that contribute toward the development of chronic disease management and performance improvement initiatives.

Participants began the Obesity QuIC by establishing an internal implementation team and assessing the current state of obesity care in their organization, providing a foundation for the October 2025 Phase 1 virtual discussions.

Through virtual discussions, interactive workshops, and quality improvement tools, participating organizations will collaborate to identify effective strategies and interventions for optimizing obesity care. Participants will have opportunities to share best practices and learn from their peers throughout, including Phase 2 and Phase 3 virtual meetings in March and August 2026.

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