
# Outcomes Report

MAY 2025

SUBMITTED BY JULIET FUNT GROUP

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Guiding Question: Where do we go from here?
FUTURE
OF OBESITY TREATMENT

# Executive Summary

The ASMBS Obesity Summit convened approximately 100 cross-sector leaders in March 2025 to confront the urgent national challenge of obesity through collaboration, innovation, and action. ASMBS assembled and invested in this Obesity Summit because treatment rates remain remarkably low, even though over 40% of U.S. adults live with obesity. The original mission and vision for the Obesity Summit is available in the appendix of this report. Of those eligible for bariatric surgery, only about 1% undergo the procedure each year.[1] Roughly 2% receive medication for obesity,[2] such as GLP-1s, and roughly 7% participate in a supervised behavior or medical weight loss program.[3] Meanwhile, obesity rates continue to rise nationally, with the CDC reporting that adult obesity prevalence increased from 30.5% in 2000 to 41.9% in 2020.[4] A wide range of treatment options exists, from lifestyle interventions and medications to surgical solutions, yet most patients are not accessing any of them.

## The Obesity Summit set out to ask: Why? More importantly: What can be done?

Over a day and a half, participants explored stigma, access, clinical definitions, and the fragmented treatment landscape. The Obesity Summit reached consensus on key barriers, outlined concrete strategies for improving care, and set in motion a multi-year, multi-stakeholder initiative centered on one central question: **what best serves the patient?**

This report captures the structure, core themes, agreed-upon priorities, and action commitments of the Obesity Summit. Patients were also present and actively participated, many bringing dual perspectives as both industry professionals and individuals with lived experience, including users of GLP-1s and bariatric surgery patients. Their voices enriched the conversation, and there was consensus that more patient representation will be critical moving forward. It is designed for both attendees and new stakeholders considering joining the initiative, providing a foundation for future collective work.

[1] Gasoyan, H., Tajeu, G., Halpern, M. T., & Sarwer, D. B. (2019). Reasons for underutilization of bariatric surgery: The role of insurance benefit design. Surgery for obesity and related diseases : official journal of the American Society for Bariatric Surgery, 15(1), 146–151. https://doi.org/10.1016/j.soard.2018.10.005

[2] Kabiri, M., Sexton Ward, A., Ramasamy, A., van Eijndhoven, E., Ganguly, R., Smolarz, B. G., Zvenyach, T., Goldman, D. P., & Baumgardner, J. R. (2020). The Societal Value of Broader Access to Antiobesity Medications. Obesity (Silver Spring, Md.), 28(2), 429–436. https://doi.org/10.1002/oby.22696

[3] Henderson J, Ehlers AP, Lee JM, et al. Weight Loss Treatment and Longitudinal Weight Change Among Primary Care Patients With Obesity. JAMA Netw Open. 2024;7(2):e2356183. doi:10.1001/jamanetworkopen.2023.56183

[4] Stierman B, Afful J, Carroll MD, et al. National Health and Nutrition Examination Survey 2017–March 2020 prepandemic data files development of files and prevalence estimates for selected health outcomes. Natl Health Stat Report. 2021;158

# Summit Approach


## Goals and Structure

The Obesity Summit was designed to promote candid dialogue, break through tribal silos (surgical, pharmacological, policy, behavioral), and generate aligned momentum across disparate sectors. Facilitated by Juliet Funt of the Juliet Funt Group, Juliet grounded the group in patient-centered inquiry and emphasized the importance of removing bias and fostering honesty. ASMBS CEO Diane M. Enos and ASMBS President Ann M. Rogers opened the event with a call to end stigma, recognize obesity as a disease, and commit to long-term change.

Participants engaged in:

- Large-group discussions framed around envisioning success and identifying blockers
- Two breakout sessions to generate table-level input on system redesign and treatment barriers
- A structured exercise using the "Dice of Fate" to reflect on key thematic areas
- Fireside panels on industry storytelling, public messaging, and collaborative models
- A hands-on language exercise in which participants drafted the "first sentence" a clinician might use to begin a conversation about obesity with a patient, focusing on empathy, respect, and clarity
- A reflective group dialogue on the patient's role in their own treatment, exploring the difficult but necessary conversation about what participation in care should look like

Facilitators used "white space" time to allow for strategic thinking. The Obesity Summit centered on setting a shared vision, identifying four categories of systemic blockers, and committing to collaborative work across sectors to address them.

Following a collective exercise focused on why each participant had gathered, the group co-created a draft vision statement to guide the initiative:

**"We will work to create a world where comprehensive obesity care is patient-centered, accessible, and stigma-free, ensuring lifelong, science-based, and compassionate management of the disease of obesity."**

**Conversations were recorded and marked using the term "whiskey" to flag moments of particular insight. You will see these throughout this report (and the remainder in the appendix).**

# Obesity Summit Activities

**Large-group discussions framed around envisioning success and identifying blockers.** Participants began the summit by collectively defining what success in obesity care would look like from multiple stakeholder perspectives. These facilitated conversations helped surface shared goals and aspirations while also grounding the dialogue in realism by identifying the most significant barriers to progress. The exercise provided a common foundation for deeper exploration throughout the summit.

**Two breakout sessions to generate table-level input on system redesign and treatment barriers.** Attendees divided into small, diverse groups to explore specific challenges in obesity care, focusing on both systemic flaws and individual-level obstacles. Each group was tasked with generating actionable insights on how to redesign care delivery, improve access, and address key treatment gaps. Table-level input was collected, synthesized, and later used to inform shared priorities and themes.

**A structured exercise using the "Dice of Fate" to reflect on key thematic areas.** This interactive activity prompted participants to reflect on real-world scenarios by rolling a die that corresponded to themes such as equity, cost, stigma, or access. Each roll sparked a focused conversation grounded in lived or professional experience, pushing participants to think critically and creatively about potential solutions. The format helped balance structure with spontaneity and encouraged open, candid dialogue.

**Fireside panels on industry storytelling, public messaging, and collaborative models.** Experts from across the obesity ecosystem shared lessons learned from public health campaigns, product rollouts, and community partnerships. The panels emphasized the importance of narrative in shifting public perception and illustrated how coordinated communication strategies can help reduce stigma and increase treatment uptake. Participants were encouraged to consider how their own organizations could engage in more effective storytelling and alignment.

**A hands-on language exercise in which participants drafted the "first sentence" a clinician might use to begin a conversation about obesity with a patient, focusing on empathy, respect, and clarity.** In this session, participants practiced crafting opening lines that would invite honest, stigma-free conversations about weight and health. Emphasis was placed on using person-first language, demonstrating compassion, and honoring patient autonomy. The exercise helped clinicians and advocates alike reflect on how word choice can either open doors or reinforce shame.

**A reflective group dialogue on the patient's role in their own treatment, exploring the difficult but necessary conversation about what participation in care should look like.** Participants engaged in a candid discussion about what it means for a patient to be an active partner in their own care journey. The conversation explored topics such as honesty, commitment, shared decision-making, and the emotional complexity of behavior change. By surfacing these insights, the group acknowledged both the responsibility and the support patients need to succeed.

"The language we use creates *or erodes* trust."

(Whiskeyed during the 'first sentence' language exercise.)

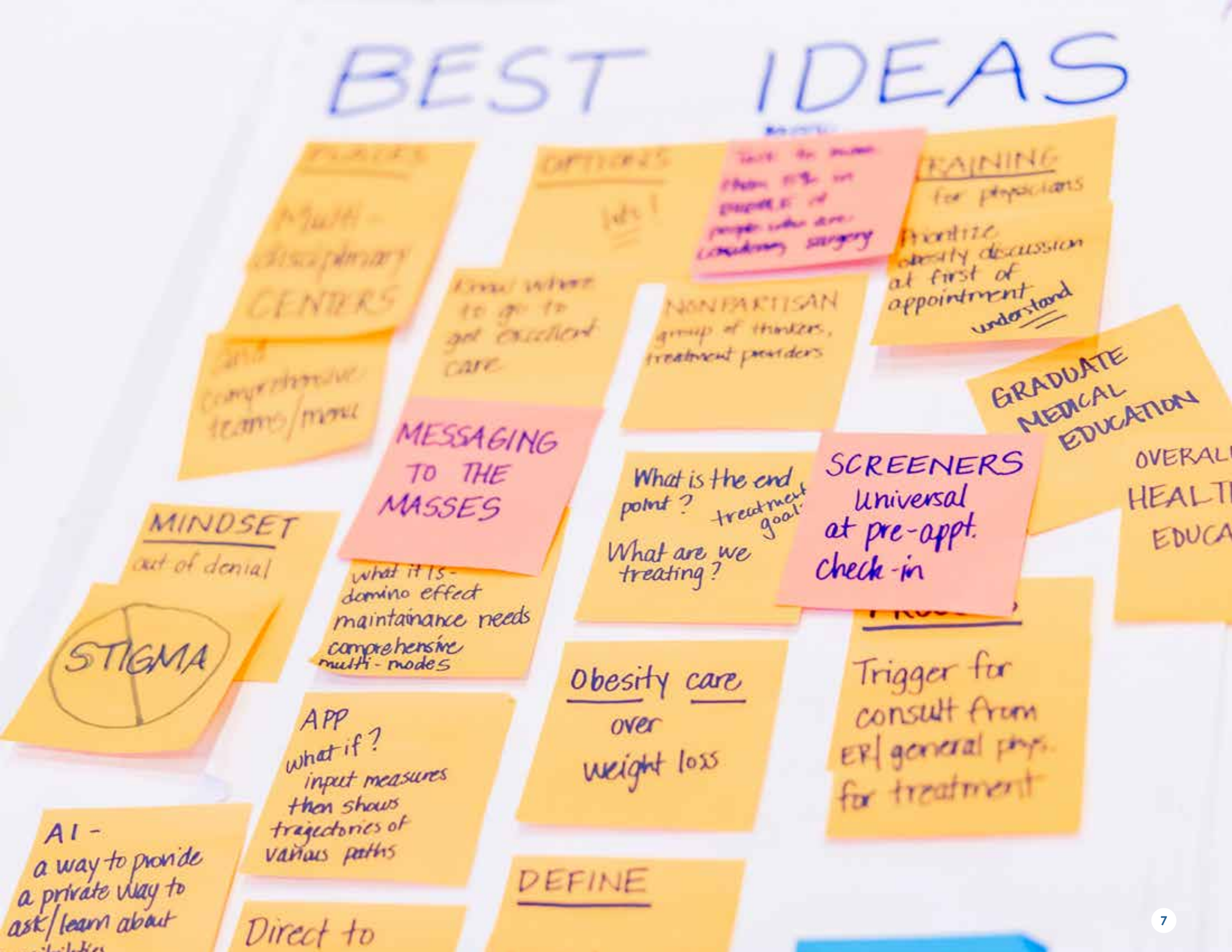
## Key Themes

Throughout the day and a half summit, there were certain themes that came up multiple times. Some of these were barriers, such as the fact that stigma against individuals with obesity is pervasive inside and outside the medical system. Others were definitional, such as the fact that obesity is a disease, not a lifestyle choice. There were even solution-oriented themes, such as a single doorway, that highlighted overarching agreement between the participants.

1. **Obesity is a Disease:** Widespread agreement emerged that obesity is a complex, chronic disease deserving of comprehensive, ongoing treatment. Yet cultural, clinical, and policy systems often treat it as a lifestyle issue.
2. **Stigma is Systemic:** Shame, blame, and bias affect every level of the care experience—from how providers are trained to how patients view themselves. Ending stigma is a foundational step in effective treatment.
3. **Fragmented Care:** The obesity treatment landscape is disjointed, with patients often left to navigate options alone. Primary care is underutilized, and referrals are inconsistent or siloed. Patients should get the treatment they need regardless of which doorway they enter.
4. **Education Gaps:** Providers lack consistent training on obesity as a disease. Few medical schools or licensing exams include comprehensive content on obesity. We fail to teach providers the soft skills to talk about the disease of obesity.
5. **Need for Standardization:** Metrics like BMI are imperfect, yet they remain dominant. Calls were made to explore alternatives, such as adiposity or the Edmonton Obesity Staging System (EOSS), and to develop consensus clinical guidelines.
6. **Access and Equity:** Insurance restrictions, transportation barriers, and cost impede access to care. Patients in rural or underserved communities face compounded disadvantages.
7. **Language and Communication:** There is a need to reframe public and clinical language to emphasize empathy, biology, and patient dignity. Providers have an obligation to talk to their patients who are sick with the disease of obesity about their disease - and options to treat it.

> "Obesity is not a moral failure. It is a biological condition, and treatable."

(Whiskeyed in a panel on changing public narratives.)


BEST IDEAS
Multi-disciplinary CENTERS
OPTIONS
TRAINING for physicians
Prioritize obesity discussion at first of appointment understand
NONPARTISAN group of thinkers, treatment providers
GRADUATE MEDICAL EDUCATION
MESSAGING TO THE MASSES
What is the end point? treatment goal
What are we treating?
SCREENERS Universal at pre-appt. check-in
MINDSET out of denial
STIGMA
what it is - domino effect maintainance needs comprehensive multi-modes
Obesity care over weight loss
Trigger for consult from ER/ general phys. for treatment
APP what if? input measures then shows trajectories of various paths
AI - a way to provide a private way to ask/learn about
DEFINE
Direct to


# Barriers to Treatment

In order to effectively organize the discussion, participants were guided through a set of exercises to identify barriers to obesity treatment. These barriers coalesced into four main types:

1. Patient
2. Clinician
3. Systemic
4. Cultural and Environmental

Attendees agreed that some of these issues were beyond the scope of what could be addressed by the participants in the room, but were important to document to clarify what could be solved. Clear identification of the problem helped the attendees refine possible solutions.

## Patient-Level Barriers

Following our focus on what best serves the patient, we first tackled barriers for patients.

**Shame, Stigma & Denial**

These deeply ingrained feelings represent a significant obstacle for individuals living with obesity. The fear of judgment, stemming from societal biases and the perception of personal failure, often leads to silence and a reluctance to seek help. Prior negative experiences within healthcare settings or personal weight loss attempts, coupled with pervasive cultural pressures that value thinness, reinforce this cycle of shame and denial, preventing individuals from acknowledging the medical nature of their condition and accessing necessary support.

**Lack of Awareness**

A significant portion of the population does not recognize obesity as a chronic, progressive disease with serious health implications. Instead, it is frequently viewed as a cosmetic concern or simply a precursor to other "real" diseases, downplaying its independent impact on health and well-being. This lack of awareness can lead to delayed or absent help-seeking behavior, as individuals may not understand the importance of medical intervention.

> “If we don’t change the ecosystem, we’ll keep getting the same results.”

(Whiskeyed during session about systemic barriers.)

> “Patients don’t fail treatment. Treatment fails patients.”

(Whiskeyed during session on shame and stigma.)

**Distrust & Fear**

Many individuals harbor apprehension and fear related to obesity treatments. Concerns about potential medication side effects, the risks associated with surgical procedures, the possibility of weight recurrence after intervention, and a perceived lack of consistent, long-term support can deter individuals from pursuing evidence-based care. These fears are often amplified by anecdotal information, misinformation, and a lack of clear communication from healthcare providers.

**Cost & Coverage Confusion**

The financial burden of obesity treatment and the complexities of insurance coverage create significant barriers. Individuals often face uncertainty about whether their treatment will be covered by insurance, fear high co-pays or unexpected medical bills, and struggle with low health insurance literacy, making it difficult to navigate the system and understand their options for accessing care. This financial insecurity can disproportionately affect marginalized communities and limit access to essential treatments.

**Psychosocial Hurdles**

Underlying mental health conditions such as anxiety and depression, coupled with a history of unsuccessful weight loss attempts, can create significant psychological barriers to seeking and adhering to obesity treatment. Furthermore, a lack of social support, or even active sabotage from family or friends who may not understand or support weight management efforts, can undermine an individual’s motivation and ability to make positive changes.

"We built a comprehensive cancer care model—why not obesity?"

(Whiskeyed during conversation about the development of "metabolic boards" and integrated treatment frameworks.)

## Clinician-Level Barriers

Since a trained medical professional should be the first line of defense in a patient's journey to treat their obesity, we next considered what prevents clinicians from engaging with patients on this important topic.

**Limited Education**

Many healthcare providers report feeling inadequately trained and unprepared to effectively diagnose and manage obesity. This lack of confidence is particularly pronounced regarding the use of anti-obesity medications, the nuances of long-term weight management care models, and the implementation of comprehensive treatment strategies beyond basic lifestyle advice. This educational gap hinders the delivery of optimal care and can contribute to provider discomfort in addressing the topic of weight with patients.

**Stigma from Providers**

Despite growing awareness of obesity as a disease, implicit biases and negative assumptions about patients' lifestyle choices (such as perceived laziness or lack of willpower) can still influence interactions between healthcare providers and individuals with obesity. This stigma can manifest in subtle or overt ways, deterring patients from openly discussing their weight concerns, seeking help, and potentially leading to suboptimal care and negative patient experiences.

**Lack of Referrals**

Even when clinicians recognize the need for specialized obesity care, they may lack clear guidelines, sufficient knowledge of available resources, or established referral pathways to connect patients with appropriate specialists, such as bariatric physicians, surgeons, registered dietitians, or mental health professionals. This absence of streamlined referral processes can result in delayed or forgone access to comprehensive and specialized care.

> “Insurance approval is not a treatment plan.”

(Whiskeyed during discussion on the limitations of insurance-driven care models)

## Systemic Barriers

Both patients and clinicians operate within existing structures, so our next set of barriers focused on systems.

**Insurance & Policy Hurdles**

The current healthcare system often presents significant obstacles to accessing comprehensive obesity care:

- **Denials for surgery, medications, and counseling:** Insurance companies frequently deny coverage for evidence-based obesity treatments, including bariatric surgery, FDA-approved anti-obesity medications, and nutritional or behavioral counseling, citing various reasons that often do not align with current medical understanding of obesity as a chronic disease.
- **Prior authorization delays:** Even when coverage is theoretically available, the lengthy and often cumbersome prior authorization processes required by insurance companies can create significant delays in accessing necessary treatments, potentially leading to disease progression and patient frustration.
- **Lack of standardized coding and treatment guidelines:** The absence of universally accepted and consistently applied diagnostic codes and treatment guidelines for obesity can contribute to inconsistencies in insurance coverage, hinder data collection for research and quality improvement, and limit the implementation of standardized, evidence-based care across healthcare systems.


> "The patient is the only stakeholder who has to live with the outcome every day."

(Whiskeyed in early plenary on system design.)

**Education Gaps**

Deficiencies in obesity education exist across the spectrum of healthcare professional training:

- **Minimal coverage in medical school or licensing exams:** Obesity and its management often receive limited attention in medical school curricula and are not adequately emphasized in professional licensing examinations, leaving many new clinicians unprepared to address this prevalent health issue effectively.
- **Outdated patient communication models:** Traditional approaches to discussing weight that focus on "asking permission" or employing judgmental language can be counterproductive and even harmful for patients with obesity, many of whom have experienced weight-related stigma. There is a need for widespread adoption of trauma-informed and person-centered communication strategies that foster trust and empower patients.

**Misinformation**

The landscape of weight management is often clouded by inaccurate and misleading information:

- **Commercialized messaging from unregulated telehealth and "quick fix" platforms:** The proliferation of unregulated online platforms and the aggressive marketing of unproven "quick fix" weight loss solutions often disseminate misinformation, preying on individuals' vulnerabilities and potentially leading to harm or ineffective treatment.
- **Public sees treatment as elective, not necessary:** Widespread misunderstanding persists that views obesity treatment as a lifestyle choice rather than a medically necessary intervention for a chronic disease. This perception can undermine public support for policy changes aimed at improving access to care and reducing stigma.

# Cultural & Environmental Barriers

This last category of barriers is the most challenging because participants recognized that no one individually or collectively participating in the summit could solve these - but they remain important to understand if we are to make progress increasing obesity treatment.

**Food Culture & Environment**

The prevailing food environment and cultural norms significantly contribute to the challenges of obesity management:

- Processed food access, cost of healthy food, and large portions: In many communities, readily available and affordable food options are often highly processed, calorie-dense, and nutrient-poor. These foods are aggressively marketed and manufactured to be nearly irresistible and addictive. Simultaneously, the cost of fresh, healthy food can be prohibitive for many individuals and families. Furthermore, cultural norms often promote large portion sizes, contributing to increased caloric intake.
- Lack of physical activity infrastructure or cultural norms against exercise: Many communities lack safe and accessible infrastructure that supports physical activity, such as sidewalks, parks, and recreational facilities. Additionally, cultural norms in some communities may not prioritize or actively discourage regular exercise, particularly for certain demographics.

**Cultural Beliefs**

Deep-seated cultural beliefs can also impede efforts to address obesity:

- Some communities equate larger body size with health or prosperity: In certain cultural contexts, a larger body size may be historically or currently associated with positive attributes such as health, fertility, or economic well-being, which can make it challenging to promote weight loss for health reasons within those communities.
- Medical weight loss will strip joy from food and social life: Some individuals and communities express fear that medical interventions for weight loss will detract from the enjoyment associated with food and social gatherings, potentially leading to resistance against such approaches.
- Familial pressure: Making different choices from friends and family can create social stigma, and result in backsliding to old habits. Finding new communities that support an individual's decision to treat their obesity is challenging.

# Proposed Solutions


Having identified these four types of barriers, participants turned to brainstorming possible solutions. These solutions included ideas that attendees acknowledged they may or may not be able to implement as a group, but were worth documenting for further prioritization. Ultimately, these solutions led to a discussion about how attendees might organize post-summit work into actionable workstreams, as outlined in the next section.

## Patient Engagement & Navigation: Empowering Individuals on Their Journey

**Patient Navigators and Coaches: Guiding and Supporting the Patient Experience**

- Implement comprehensive patient navigation programs utilizing trained navigators or metabolic coaches as dedicated points of contact.
- Guide patients through every step of their journey, from initial education to scheduling, care coordination, and ongoing support for treatment adherence and follow-up.
- Connect patients with relevant community resources and address logistical challenges such as transportation and childcare.
- Ensure that navigators receive specialized training in motivational interviewing, health literacy, and culturally competent communication.

**Centralized Entry Points ("One Front Door"): Streamlining Access to Care**

- Establish easily accessible and centralized entry points for patients seeking obesity care, such as a single digital or physical portal.
- This system should offer clear information about available services, facilitate seamless intake and triage processes, and provide efficient scheduling capabilities.
- Utilize technology such as QR codes and user-friendly online platforms to enhance accessibility.
- Ensure that the centralized entry point is well-publicized, easy to locate, and offers multilingual support and accommodations for individuals with disabilities.

> “Patients are already using Google and AI to find information. We need to meet them where they are.”

(Mentioned explicitly in the group design session focused on virtual front doors and AI-driven entry to care.)

**Support Groups and Peer Networks: Fostering Connection and Resilience**

- Actively encourage the formation and participation in both local and virtual support groups and peer networks.
- These platforms provide opportunities for peer navigation, sharing experiences and coping strategies, and developing supportive relationships.
- Facilitate the connection of patients with others who have undergone similar treatments or are facing similar challenges.
- Support group facilitators should be trained to create safe and inclusive environments that address issues of shame, foster resilience, and reduce treatment dropout rates.
- Promote awareness of available support resources through clinics, online platforms, and community organizations.

**Patient Education Campaigns: Raising Awareness and Empowering Action**

- Launch comprehensive and culturally sensitive public education campaigns aimed at reframing obesity as a medical issue.
- Utilize a variety of communication channels, including PSAs, social media, and community-based events, to disseminate accurate information about causes, consequences, and treatment pathways.
- Actively work to combat stigma, dispel misinformation, and empower individuals to seek appropriate medical care.
- Develop educational materials in multiple languages and tailored to diverse audiences.
- Collaborate with community leaders and trusted messengers to ensure the reach and effectiveness of these initiatives.

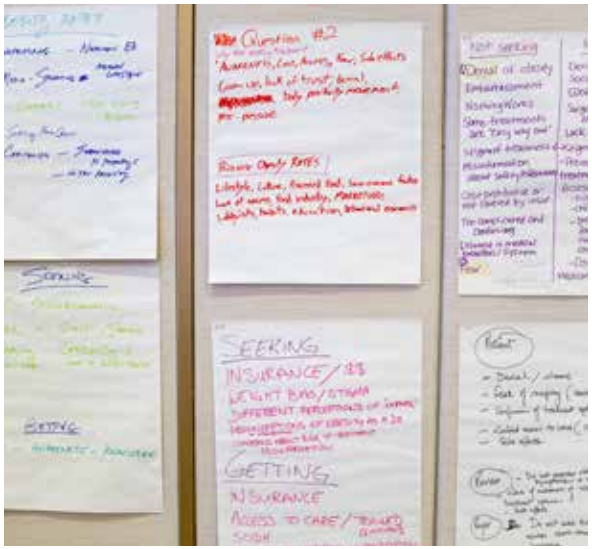
# Clinical & Provider-Focused Solutions: Reimagining Obesity Care

**Normalize Obesity as a Treatable Disease: Reframing the Narrative**

- Implement widespread educational initiatives for healthcare professionals on the biological, genetic, and environmental factors contributing to obesity.
- Encourage the consistent use of neutral, scientifically accurate terminology in patient interactions, medical records, and public discourse.
- Integrate patient testimonials and expert opinions into awareness campaigns to humanize the condition and destigmatize seeking treatment.
- Develop and disseminate communication guidelines for providers across all specialties to ensure consistent and empathetic messaging.
- Evaluate and update medical school curricula and continuing medical education programs to emphasize the treatable nature of obesity and the importance of a patient-centered approach.

**Trauma-Informed Communication: Cultivating Trust and Safety**

- Mandate comprehensive training for all clinicians on the principles of trauma-informed care.
- Equip providers with the skills to ask permission sensitively before discussing weight and initiate conversations non-judgmentally.
- Actively employ shared decision-making models that prioritize patient autonomy and preferences.
- Implement standardized protocols for screening for trauma in a safe and supportive environment.
- Foster a culture of open communication where patients feel empowered to share their experiences without fear of stigma or retraumatization.
- Provide resources and support for both patients and providers on navigating the emotional and psychological aspects of obesity and its treatment.




**Provider Education & Certification Reform: Building a Knowledgeable Workforce**

- Mandate comprehensive and up-to-date obesity-specific training as a core component of medical school curricula and physician licensing examinations.
- Expand training scope to encompass metabolic health, behavioral science, pharmacotherapy, and surgical interventions.
- Actively integrate elective courses, clinical experiences, and interdisciplinary exposure opportunities.
- Establish clear competencies and assessment criteria for obesity care within medical education and board certifications.
- Promote ongoing professional development and continuing medical education on the latest advancements.
- Encourage specialized fellowships and advanced training programs in obesity medicine.

**Metabolic Boards for Complex Cases: Collaborative Expertise for Optimal Outcomes**

- Establish multidisciplinary metabolic boards for the comprehensive review and collaborative management of complicated obesity cases.
- These boards should bring together physicians from relevant specialties, registered dietitians, behavioral health specialists, and other allied health professionals.
- Implement standardized protocols for case presentation, discussion, and the development of integrated, patient-centered treatment plans.
- Facilitate shared decision-making, ensure appropriate utilization of multidisciplinary expertise, and promote adherence to evidence-based guidelines.
- Regularly evaluate the effectiveness of metabolic boards in improving patient outcomes and optimizing resource allocation.

> “The provider should go to the community, not the other way around.”

(Whiskeyed during conversation about equity strategies. Participants proposed mobile vans, workplace visits, school-based outreach.)

# Care Model & Delivery Innovations: Transforming How Obesity Care is Provided

**Integrated, Multidisciplinary Care Hubs: A Holistic Approach to Treatment**

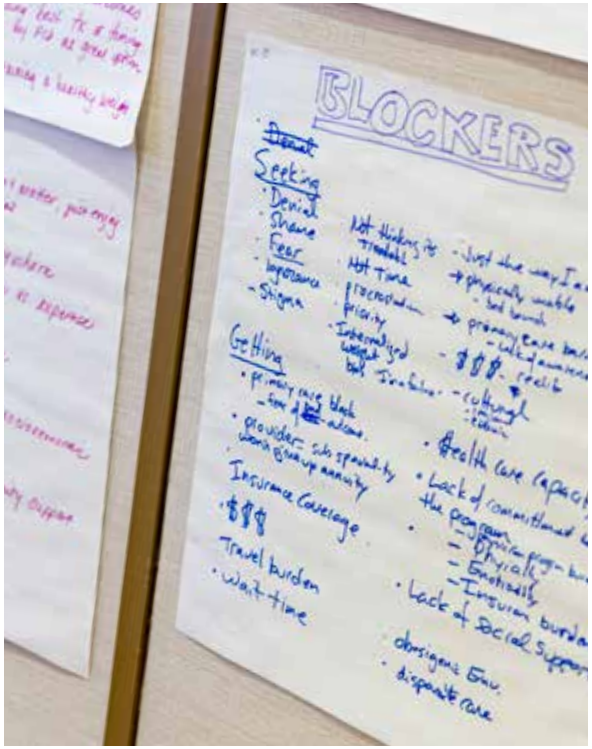
- Move towards the development and implementation of integrated, multidisciplinary care hubs offering comprehensive obesity-related services.
- These hubs should seamlessly integrate medical, surgical, behavioral, and nutritional care, delivered by a team of specialized professionals working collaboratively.
- Offer both in-person and virtual consultation options to enhance accessibility.
- Streamline communication and information sharing among team members to ensure coordinated and patient-centered care.
- These integrated hubs can improve patient convenience, reduce fragmentation of care, and optimize treatment outcomes.

**Flexible Access (Virtual + In-Person): Meeting Patients Where They Are**

- Expand the use of telehealth for virtual consultations and follow-up appointments.
- Deploy mobile health units to reach underserved communities.
- Partner with community health centers to expand local access.
- Explore opportunities for home-based care when appropriate.
- Leverage technology to facilitate remote monitoring and support.

> “Care is not a straight line—it’s a loop with many restarts.”

(Whiskeyed during discussion of fluidity, long-term navigation, chronicity and wrap around models.)




**Customizable, Patient-Centered Pathways: Tailoring Care to Individual Needs**

- Shift away from standardized approaches and embrace the development of customizable, patient-centered care pathways.
- Personalize care plans based on a comprehensive assessment considering age, language, culture, associated conditions, prior attempts, and individual preferences.
- Utilize shared decision-making to actively involve patients in the development of their care plans.
- Regularly review and adjust treatment strategies based on individual progress and feedback.

**Behavioral Health Integration: Addressing the Psychosocial Drivers of Obesity**

- Integrate qualified psychologists and therapists directly into obesity care teams.
- Offer essential support in addressing underlying psychosocial factors such as shame, trauma, depression, anxiety, and disordered eating.
- Provide routine screening for mental health conditions and offer accessible and integrated behavioral health interventions.
- Foster seamless communication and collaboration between medical, surgical, nutritional, and behavioral health providers.

"We need to stop designing care for what's easy to bill, and start designing it for what's needed."

(Whiskeyed in care coordination discussion.)

# Policy & System-Level Interventions: Formalizing Obesity Treatment Structures

**Insurance Reform & Coverage Expansion:**

- Advocate for comprehensive and mandatory insurance coverage for all evidence-based obesity treatments (medications, surgery, intensive behavioral therapy, nutrition counseling).
- Work to eliminate onerous prior authorization processes.
- Advocate for transparent and streamlined prior authorization based on clear clinical criteria.
- Standardize and clarify billing codes related to obesity care for accurate reimbursement and reduced administrative burden.
- Foster greater access and reduce disparities in care.

**Guidelines & Standardized Pathways:**

- Prioritize the development and widespread dissemination of national clinical care pathways.
- Ensure pathways are evidence-based and incorporate the latest research.
- Pathways should encompass the full continuum of care (screening, diagnosis, lifestyle interventions, pharmacotherapy, surgical options).
- Include specific protocols for managing weight recurrence and addressing the long-term nature of obesity.
- Emphasize multidisciplinary collaboration with clear roles for various healthcare professionals.
- Ensure coordinated and patient-centered care.

> “We’re expecting a fragmented system to deliver coordinated care.”

(Whiskeyed during system redesign exercises where participants described siloed funding, fractured care teams.)

> “We can’t just build another hub that only works for well-off patients in urban areas.”

(Whiskeyed during commentary about barriers like parking, child care, and fear of large academic centers. Participants advocated for virtual and community-integrated models.)

**Public-Private Partnerships:**

- Foster and strengthen public-private partnerships to expand obesity prevention and treatment efforts.
- Engage with employers to promote workplace wellness programs and access to obesity care benefits.
- Collaborate with educational institutions to implement nutrition and physical activity programs.
- Partner with health insurance payers to advocate for policy changes improving coverage and access.
- Engage with community-based organizations, faith-based institutions, and local governments to scale effective solutions.
- Leverage diverse resources, expertise, and networks to create supportive environments.

**Address Social Determinants of Health:**

- Actively address underlying social determinants of health contributing to obesity disparities.
- Implement community-based strategies targeting key social factors.
- Improve access to reliable and affordable transportation.
- Address food insecurity through increased access to affordable and nutritious foods.
- Reduce educational gaps through health literacy programs and promoting healthy habits in schools.
- Improve neighborhood infrastructure by creating safe spaces for physical activity, increasing access to healthy food retailers, and reducing exposure to environmental factors.
- Create healthier communities and promote health equity.

# Participating Organizations

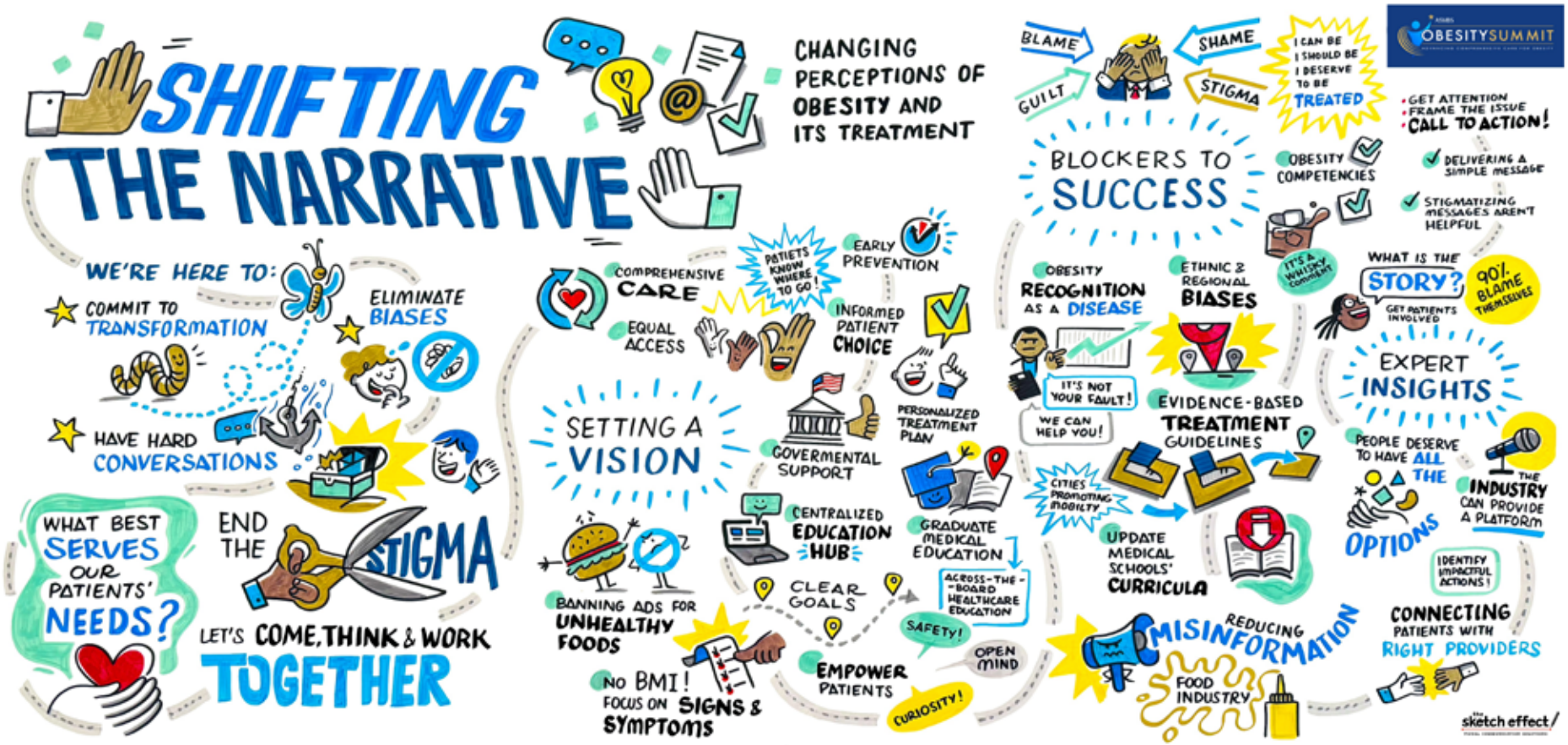
A Good Work Company
Academy of Nutrition and Dietetics (AND)
American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American Academy of Physician Associates (AAPA)
American Academy of Sleep Medicine (AASM)
American Association of Clinical Endocrinology (AACE)
American Association of Nurse Practitioners (AANP)
American Board of Obesity Medicine (ABOM)
American Board of Obesity Medicine Foundation
American College of Emergency Physicians (ACEP)
American College of Gastroenterology (ACG)
American College of Physicians (ACP)
American College of Sports Medicine (ACSM)
American Gastroenterological Association (AGA)
American Heart Association (AHA)
American Medical Association (AMA)
American Psychological Association (APA)
American Society for Gastrointestinal Endoscopy (ASGE)
American Society for Metabolic and Bariatric Surgery (ASMBS)
American Society for Metabolic and Bariatric Surgery (ASMBS)/TREO Foundation
American Society of Anesthesiologists (ASA)
American Society of Clinical Oncology (ASCO)
Boston Scientific
Canadian Association of Bariatric Physicians and Surgeons (CABPS) Children's Hospital Los Angeles and Keck School of Medicine of USC, Department of Pediatrics
Communication Partners & Associates
ConscienHealth
Duke University Health System
Fidens Strategy
International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO)
International Society for the Perioperative Care of the Obese Patient (ISCOP)
Intuitive
Johnson & Johnson MedTech
Juliet Funt Group

(continued)

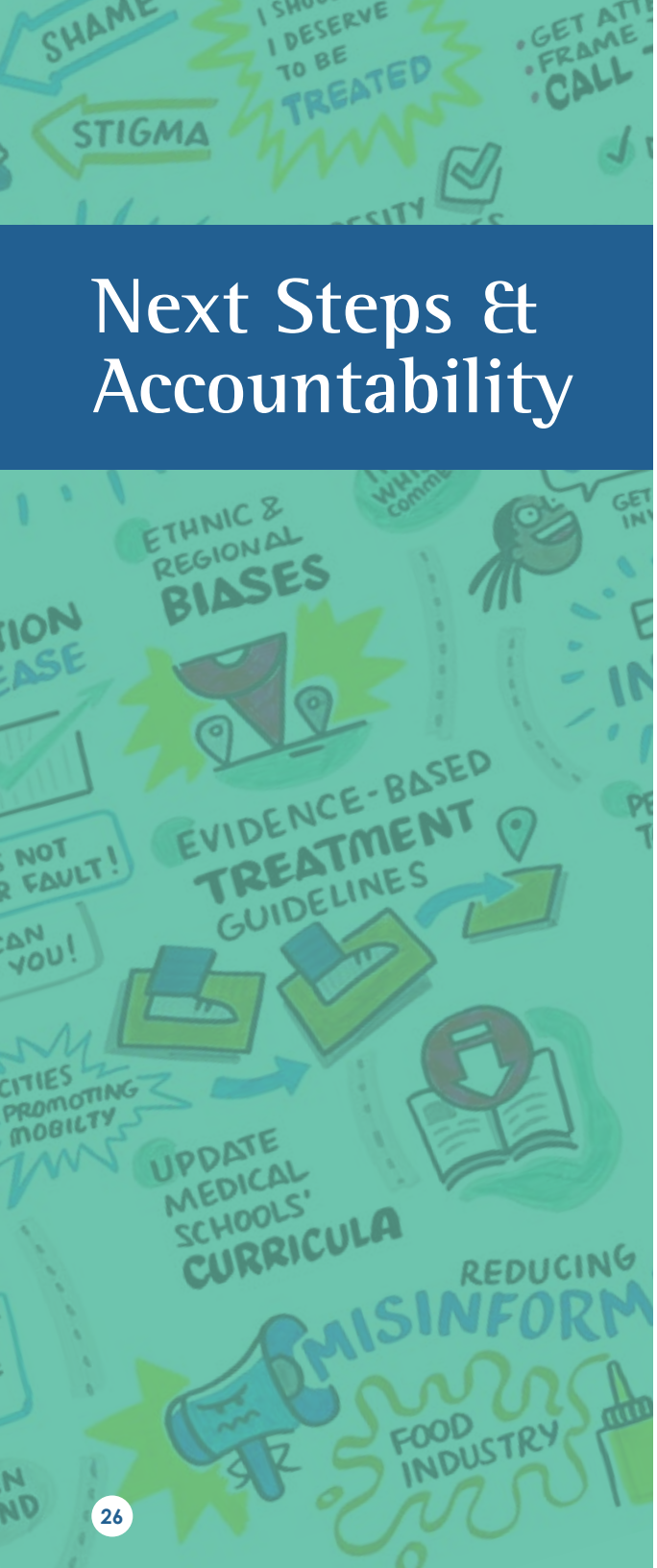

## Participating Organizations Continued

Lancet Commission
MBSAQIP
Medtronic
National Lipid Association (NLA) Obesity Action Coalition (OAC)
Obesity Canada
Obesity Care Advocacy Network (OCAN)
Obesity Medicine Association (OMA)
Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)
Society of Behavioral Medicine (SBM)
STOP Obesity Alliance
Teleflex
The Obesity Society (TOS)
The Society for Surgery of the Alimentary Tract (SSAT)
Washington Policy Advisor, Potomac Currents


BREAKING BARRIERS
EXPANDING ACCESS TO COMPREHENSIVE OBESITY CARE
OBESITYSUMMIT
BLOCKER 1
THE PUBLIC RELATIONS GAP
KEEP YOUR MESSAGE
SIMPLE, EVIDENCE-BASED
WE CAN HELP
MAKE PATIENTS FEEL SAFE
AWARENESS
ACROSS-THE-BOARD TEACHING ON OBESITY
CASE-BASED LEARNING
REIMBURSEMENT
OVERCOMING INERTIA
CHALLENGING OUTDATED PUBLIC PERCEPTION
UTILIZATION
MORE HUMAN STORIES!
DATA
EFFECTIVE WELLNESS PROGRAMS
PERSONALIZED PLANS
BLOCKER 2
ENGAGE EMPLOYERS
THE ACCESS GAP
VALUE-BESED CARE MODELS
NON-LINEAR APPROACH
MORE INNOVATIVE CARE
OVERCOMING INSURANCE COVERAGE GAPS
IT'S COST-SAVING!
RETURN ON INVESTMENT
BLOCKER 3
THE CARE CONTINUUM GAP
OUR VISION:
PLACE
PEOPLE
PROCESS
PATIENT NAVIGATOR
NEEDS ASSESSMENTS
NORMALIZING DISCUSSIONS
MULTI-DISCIPLINARY CARE TEAM
FOCUS ON COMMUNITY-BASED APPROACH
VIRTUAL CARE MODEL:
DIGITAL FRONT-DOOR
REFORM FOOD POLICIES
APPS AS A TOOL FOR EDUCATION
WORDS MATTER!
HANDS-ON TRAINING FOR CLINICIANS
BETTER TRAINING
VISUAL TOOLS
FOR ALL THE FRONTLINE PROVIDERS
CERTIFICATION EXAMS
GUEST LECTURES
BLOCKER 4
THE EDUCATION GAP
OBESITY AS A SPECTRUM
OBESITY SENSETIVITY TRAINING
HELP PROVIDERS FEEL MORE CONFIDENT
RESULTS
ENCOURAGE BETTER TREATMENT
MULTIPLE OPTIONS!
APPROPRIATE CARE!
CHANGING PERSPECTIVE REQUIRES:
COMMITMENT
INTEREST
OPEN MIND
the sketch effect


SHIFTING THE NARRATIVE
CHANGING PERCEPTIONS OF OBESITY AND ITS TREATMENT
OBESITYSUMMIT
WE'RE HERE TO:
COMMIT TO TRANSFORMATION
ELIMINATE BIASES
HAVE HARD CONVERSATIONS
END THE STIGMA
WHAT BEST SERVES OUR PATIENTS' NEEDS?
LET'S COME, THINK & WORK TOGETHER
SETTING A VISION
COMPREHENSIVE CARE
EQUAL ACCESS
PATIETS KNOW WHERE TO GO!
EARLY PREVENTION
INFORMED PATIENT CHOICE
PERSONALIZED TREATMENT PLAN
GOVERMENTAL SUPPORT
CENTRALIZED EDUCATION HUB
GRADUATE MEDICAL EDUCATION
ACROSS-THE-BOARD HEALTHCARE EDUCATION
CLEAR GOALS
BANNING ADS FOR UNHEALTHY FOODS
NO BMI! FOCUS ON SIGNS & SYMPTOMS
EMPOWER PATIENTS
SAFETY!
OPEN MIND
CURIOSITY!
BLAME
SHAME
GUILT
STIGMA
I CAN BE
I SHOULD BE
I DESERVE
TO BE TREATED
BLOCKERS TO SUCCESS
OBESITY COMPETENCIES
OBESITY RECOGNITION AS A DISEASE
IT'S NOT YOUR FAULT!
WE CAN HELP YOU!
ETHNIC & REGIONAL BIASES
EVIDENCE-BASED TREATMENT GUIDELINES
CITIES PROMOTING MOBILITY
UPDATE MEDICAL SCHOOLS' CURRICULA
REDUCING MISINFORMATION
FOOD INDUSTRY
IT'S A WHISKY COMMENT
WHAT IS THE STORY?
GET PATIENTS INVOLVED
90% BLAME THEMSELVES
EXPERT INSIGHTS
PEOPLE DESERVE TO HAVE ALL THE OPTIONS
THE INDUSTRY CAN PROVIDE A PLATFORM
IDENTIFY IMPACTFUL ACTIONS!
CONNECTING PATIENTS WITH RIGHT PROVIDERS
GET ATTENTION
FRAME THE ISSUE
CALL TO ACTION!
DELIVERING A SIMPLE MESSAGE
STIGMATIZING MESSAGES AREN'T HELPFUL
the sketch effect

# Next Steps & Accountability




## Workstream Recommendations

Once the attendees had brainstormed and categorized all possible solutions, we sought to establish an actionable pathway forward. In a large group discussion, attendees discussed their own commitment to advancing our shared goal of increasing obesity treatment. Participants identified and committed to organizing into six ongoing workstreams, each responsible for producing outputs and driving progress:

1. **MESSAGING & PUBLIC NARRATIVE**
   - Develop a unifying patient-centered message
   - Engage media, employers, and influencers
   - Launch a national campaign to counter stigma
2. **EDUCATION & TRAINING**
   - Create curriculum modules for medical schools
   - Advocate for board certification reform
   - Provide Continuing Medical Education (CME) for existing providers
3. **CLINICAL STANDARDS & METRICS**
   - Define consensus guidelines
   - Pilot alternatives to Body Mass Index (BMI)
   - Create clinical playbooks for Primary Care Physicians (PCPs)
4. **PATIENT ACCESS & EQUITY**
   - Map treatment deserts and access gaps
   - Partner with payers to improve coverage
   - Integrate telehealth and extended hours
5. **POLICY & ADVOCACY**
   - Lobby for Current Procedural Terminology (CPT) code expansion
   - Advance obesity parity legislation
   - Coordinate multi-society sign-ons
6. **TECHNOLOGY & TOOLS**
   - Build digital portals and apps for patients
   - Leverage Artificial Intelligence (AI) to personalize treatment
   - Create a shared data infrastructure

# What Happens Next

- A survey will be distributed to allow participants to select preferred workstreams
- Each workstream will meet at least quarterly, with interim working calls
- A third-party project manager will support scheduling, deliverable tracking, and communication
- Participants should submit relevant case studies, research, and tools to obesitySummit@asmbs.org
- A follow-up Summit will be scheduled with virtual access to broaden participation

A work-stream-specific summit is planned for November 2025, and a comprehensive Summit is scheduled for May 2026 to continue this work and expand participation across sectors.

The ASMBS and facilitation team will steward this collaborative effort over the next 12 months, ensuring that this Summit marks the beginning, not the end, of meaningful progress toward improved obesity care in the United States.

> **"If you want different outcomes, you have to build a different system."**

(Whiskeyed in closing group reflection.)

# Conclusion

The inaugural Obesity Summit was an intense two day discussion about a topic that could not be more important to the health outcomes of Americans. We hope to set the standard for creating a comprehensive care approach that will serve as an example to other countries and even other diseases. ASMBS is proud to have instigated this work with the partnership of a wide range of stakeholders who are all working towards the same goal: increasing obesity treatment.

APPENDIX A

# Whiskey Moments

## (Insight Highlights)

The facilitation team used the word "whiskey" to denote especially powerful statements. Highlights included:

- **"If we don't stop talking around it and start naming it, we will never fix it."** (Whiskeyed during discussion on shame and silence in provider training.)
- **"Obesity is not a moral failure. It is a biological condition, and treatable."** (Whiskeyed in a panel on changing public narratives.)
- **"The patient is the only stakeholder who has to live with the outcome every day."** (Whiskeyed in early plenary on system design.)
- **"We need to stop designing care for what's easy to bill, and start designing it for what's needed."** (Whiskeyed in care coordination discussion.)
- **"If you want different outcomes, you have to build a different system."** (Whiskeyed in closing group reflection.)
- **"Wherever you enter the system, you should end up in the right place."** (Discussed in a breakout session on comprehensive care models and systems design.)
- **"We can't build a new system only around the most motivated patients."** (Raised during group discussion on equity and patient engagement across diverse readiness levels.)
- **"We can't just build another hub that only works for well-off patients in urban areas."** (Noted in comments about barriers like parking, child care, and fear of large academic centers. Participants advocated for virtual and community-integrated models.)
- **"Patients are already using Google and AI to find information. We need to meet them where they are."** (Mentioned explicitly in group design session focused on virtual front doors and AI-driven entry to care.)
- **"We are overbuilding around procedures and underbuilding around people."** (Whiskeyed during group conversations about prioritizing navigators, behavioral health, and distributed teams rather than just surgical sites.)

- **"The language we use creates or erodes trust."** (Explored extensively during the "first sentence" activity and language exercise.)
- **"You should be able to start your care journey at home."** (Discussed in virtual care sections and sessions about QR code-enabled access, telemedicine, and "magic portal" concepts.)
- **"We built a comprehensive cancer care model—why not obesity?"** (Whiskeyed during conversation about the development of "metabolic boards" and integrated treatment frameworks.)
- **"Our care is dictated by what insurance covers—not by what patients need."** (Stated during early session on blockers. Cost, coverage confusion, and denials were major themes.)
- **"The provider should go to the community, not the other way around."** (Raised as an equity strategy. Participants proposed mobile vans, workplace visits, school-based outreach.)
- **"We're expecting a fragmented system to deliver coordinated care."** (Commentary during system redesign exercises where participants described siloed funding, fractured care teams.)
- **"Care is not a straight line—it's a loop with many restarts."** (Brought up in discussions of fluidity, long-term navigation, and wraparound models. Chronicity mentioned throughout.)
- **"Patients shouldn't see the mess."** (Discussed in design sessions on comprehensive care models.)
- **"Every touchpoint should offer treatment."** (Whiskeyed during discussion about solutions, the use of QR codes, on-demand access, and centralized portals.)
- **"Patients don't fail treatment. Treatment fails patients."** (Mentioned in session on shame, stigma, and trauma-informed approaches to care and discussed in language exercises and commentary from providers on reframing failure.)
- **"Obesity care should be as standard as prenatal care."** (Appears as part of a visioning session comparing obesity care to cancer and prenatal models, advocating for similar infrastructure and long-term investment.)
- **"Insurance approval is not a treatment plan."** (Point made directly during a discussion on the limitations of insurance-driven care models, emphasizing that "model is dictated by insurance.")
- **"We need to treat obesity like the chronic, relapsing disease it is—not a personal failing."** (Brought up in a fireside discussion about education, long-term follow-up, and destigmatizing the chronicity of obesity.)
- **"If we don't change the ecosystem, we'll keep getting the same results."** (Theme emerged from critiques of food marketing, social determinants, and policy environments—mentioned during sessions about systemic barriers.)
- **"You can't coordinate care in a vacuum."** (Idea voiced repeatedly in discussions of navigator roles, data-enabled referrals, and linking siloed specialties to support the patient through a coordinated journey.)

APPENDIX B

# Expanded Vision Implementation Roadmap

## Expanded Vision Implementation Roadmap (2025–2028)

| YEAR | MILESTONES |
|---|---|
| 2025 | Finalize the infrastructure, assign workstream leads, establish pilot sites, and initiate the public narrative campaign. Convene follow-up engagement via a second, abbreviated Obesity Summit before the ASMBS Weekend Meeting in Louisville, KY (November). |
| 2026 | Host a follow-up Obesity Summit at mid-year with additional engagement at the ASMBS Annual Meeting in San Antonio, TX (May). Report pilot outcomes, publish guidelines, formally launch education modules, and initiate legislative outreach. |
| 2027 | Expand successful pilots nationally, integrate campaign into professional and consumer health spaces, and drive payer and policy engagement at scale. |
| 2028 | Measure progress through outcome dashboards, publish a national obesity report card, advocate for systemic policy changes, and achieve full integration into healthcare systems. |

# Obesity Care Coordination Council (OCCC)

The OCCC will act as the central oversight and coordination body for all workstreams. Co-chaired by ASMBS and one rotating stakeholder group (e.g., payer, advocacy, academic,
or tech leader), the OCCC will:

- Provide strategic governance: Maintain alignment with the Obesity Summit vision and mission.
- Monitor progress: Oversee deliverables and timelines for each workstream.
- Facilitate cross-sector collaboration by hosting quarterly coordination calls and two in-person Obesity Summits.
- Steward resources: Align and report on funding, partnerships, and return on investment (ROI).
- Enhance public transparency by publishing annual updates, key metrics, and relevant dashboards.

Membership will include: two representatives from each workstream, two patient advocates, and up to six rotating at-large members representing key stakeholders across sectors. The Council will be supported by JFG consultants, and administrative support will be provided by ASMBS.


APPENDIX C

# Obesity Summit: What and Why are We Trying to Accomplish?

(Original Summit Proposal)

The Obesity Summit will convene 100 key opinion leaders across healthcare, industry, patient advocacy, and policy for a professionally facilitated and highly collaborative event. Together, we will develop actionable strategies to integrate comprehensive care models for obesity, elevate public education, and improve access to evidence-based treatments such as intensive behavior therapy (IBT), pharmacotherapy, and metabolic and bariatric surgery (MBS).

## Mission Statement

We aim to develop a consistent and comprehensive approach to the disease of obesity and a working coalition of healthcare, industry, advocacy and policy leaders who will collaboratively implement the Obesity Summit's output. The Obesity Summit is a formative step to develop a holistic, evidence-based and integrated approach to reducing obesity in the United States. We hope to establish the U.S. as a leader in breaking down barriers to treatment that sets an example for similar international efforts.

## Vision Statement

Obesity is one of the most pressing public health challenges of our time, impacting millions of individuals and placing immense strain on healthcare systems worldwide. Despite significant advancements in treatment options, including metabolic and bariatric surgery (MBS), anti-obesity medications, and comprehensive care models, access to effective, evidence-based obesity treatment remains limited. Stigma, policy barriers, and a fragmented approach to care continue to hinder progress.

The Obesity Summit is a transformative, high-impact gathering of key stakeholders—including healthcare leaders, policymakers, patient advocates, industry innovators, and providers—designed to address these critical challenges and develop a unified, scalable framework for comprehensive obesity care.

Our vision is to foster collaboration, align strategic initiatives, and drive systemic change to ensure that obesity is recognized, treated, and resourced as a chronic disease within an integrated healthcare model. By bridging gaps in access, education, and policy, we will accelerate a shift toward whole-patient, multi-disciplinary care, enabling more individuals to receive the treatment they need and deserve.

# A Call to Action

The Obesity Summit is not just a conversation—it is a catalyst for change. Our collective expertise, commitment, and strategic action will determine the future of obesity care. Together, we will move beyond fragmented solutions and toward a fully integrated, equitable approach to treating obesity—one that improves health outcomes, reduces disparities, and ultimately, moves the needle on this critical public health issue.

Through this Obesity Summit, we can set the foundation for a future where every person affected by obesity has access to the highest standard of care—free from stigma, with the support of a system that truly prioritizes their well-being.

# Expected Outcomes

1. **A Shared Understanding of Barriers and Opportunities**–Deep dive into the challenges obstructing comprehensive obesity care.
2. **A Collaborative, Multi-Stakeholder Roadmap**—Clearly defined actions, ownership, and milestones for the next 1-3 years.
3. **Commitment from Key Stakeholders**—Solidified partnerships and accountability mechanisms to drive change.

APPENDIX D

# Moving the Needle

(ASMBS Public Education and Consumer Marketing Campaign Proposal)

June 2024

## Moving the Needle

Amid the increasing attention afforded to the new anti-obesity drugs, the American Society for Metabolic and Bariatric Surgery (ASMBS) is embarking on a transformative multi-year Public Education and Consumer Marketing Campaign to enhance the understanding, acceptance, and utilization of metabolic and bariatric surgery (MBS) in the context of comprehensive care models. This initiative aims to reshape perceptions, generate inquiries, increase procedures, improve access, and reduce the stigma associated with both obesity and MBS.

This multi-faceted campaign combines evidence-based research, expert opinion, patient and healthcare professional advocacy, social media, and digital outreach, engaging content, media outreach, and key collaborations with healthcare providers, patient advocacy groups, professional societies, media influencers and bloggers, patients, and industry partners. The partnerships we form or strengthen are pivotal to the campaign

At the campaign's core is developing high-quality multimedia content and strategic outreach to potential patients through stories in major news outlets, paid media campaigns, and major consumer and professional news outlets (and professional societies) to ensure our message reaches and resonates with key stakeholders.

This campaign represents a significant opportunity to change the dynamics of obesity treatment in America and influence critical stakeholders to strengthen their support or newly engage in the issues that have kept MBS one of the most effective but least utilized treatments in medicine. By supporting this campaign, supporters will be investing in a project that enhances patient care and improves quality of life, furthering the mission of ASMBS in combating obesity and elevating health standards against the most significant public health problem in America.

This proposal aims to secure funding for the ASMBS Public Education and Consumer Marketing Campaign, a multi-year initiative designed to enhance the understanding, value, and acceptance of MBS as a crucial treatment for obesity. This campaign aims to shift public and professional attitudes, advocate for policy changes, and promote comprehensive care models while combating obesity-related stigma. By integrating strategic research, innovative content, compelling storytelling, and broad stakeholder collaboration, we seek to improve patient outcomes and quality of life, making MBS more accessible and accepted. The top three needs of the ASMBS Public Education and Consumer Marketing Campaign are:

1. **Funding and Resources:** Securing adequate funding is essential to cover the comprehensive costs of market research, content development, extensive media buys, and ongoing campaign activities. This financial support will ensure the campaign can be launched effectively and sustained over multiple years.
2. **Strategic Partnerships:** Building solid collaborations with key stakeholders such as healthcare providers, industry partners, patient advocacy groups, and media outlets is crucial. These partnerships will give the campaign the necessary expertise, credibility, and channels for disseminating its message widely and effectively.
3. **Public and Professional Engagement:** Engaging the public and healthcare professionals is vital to changing perceptions about MBS and advocating for policy changes. This engagement will help dismantle stigma, influence health policies, and improve the acceptance and understanding of MBS as a treatment option.

# To Key Stakeholders and Partners:

The ASMBS Public Education and Consumer Marketing Campaign presents a unique and impactful opportunity for participation and support from key stakeholders and funders. By investing in this initiative, participants will play a pivotal role in a transformative campaign to enhance population health outcomes and shape the future of obesity treatment. Here are the significant points outlining the opportunity for involvement:

1. **Impact on Health:** Participants will contribute to a campaign that directly improves the understanding, value, and acceptance of metabolic and bariatric surgery (MBS) as a vital treatment for obesity. This involvement supports a broader mission to elevate health standards, health equity, and quality of life.
2. **Visibility and Influence:** Stakeholders and funders will gain visibility as leading contributors to a significant public health initiative. This visibility comes with opportunities to influence policy and practice in healthcare, particularly in how obesity and its treatments are perceived and managed across various platforms and audiences.
3. **Strategic Partnerships:** Joining this campaign allows for creating and strengthening strategic partnerships with leading organizations, healthcare providers, and industry experts. These partnerships enable collaborative efforts that maximize resource utilization and expertise, fostering innovative solutions and integrated approaches to public health challenges.
4. **Market Expansion and Engagement:** For industry partners, especially those in the medical and healthcare sectors, participation directly leads to engaging with existing markets and untapped demographics. This campaign will provide a platform to showcase advancements in medical treatments and technologies related to obesity and metabolic health.
5. **Corporate Social Responsibility (CSR):** Participation aligns with corporate social responsibility goals by demonstrating a commitment to addressing significant health issues, supporting community health, and engaging in public education. This enhances the image of MBS and supports long-term brand loyalty among consumers who value health and wellness.
6. **Return on Investment:** This campaign's broad exposure and strategic positioning promise a significant return on investment through brand association, enhanced reputation, and the potential to influence market dynamics and policy decisions in the healthcare sector.


ASMBS
OBESITYSUMMIT
ADVANCING COMPREHENSIVE CARE FOR OBESITY