



2025

STRATEGIC PROGRAMS OF WORK

INTEGRATED HEALTH LEADERSHIP COUNCIL

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EXECUTIVE SUMMARY: IHLC Strategic Programs of Work

Across five pillars—*Membership Value & Retention, Education & Professional Development, Specialty Recognition & Comprehensive Care, Leadership & Mentorship Development, and Innovation, Revenue, & Access*—the IHLC’s thematic analyses reveal a tightly converging set of needs: speed, clarity, structure, visibility, and execution discipline.

While each pillar generated rich discussion, the dominant insight is that IH is transitioning from *goal-based strategic planning* to *a programmatic operating model* that is flexible, annualized, measurable, and aligned with **societal** and presidential initiatives.

This shift directly responds to patterns seen in all historical IH plans (2014–2025), which consistently emphasize:

- Multidisciplinary identity and visibility
- Member value and retention
- Education pathways and credentials
- Leadership pipeline and governance clarity
- Access to care and coordinated advocacy

The 2025 working session marks the first time these themes have been unified into cross-pillar programs that reinforce one another and operationalized in a sustainable, execution-focused model.

EXECUTIVE SUMMARY: Cross-Pillar Insights

IH Must Clearly Articulate Its Value—Internally and Externally

Across Membership, Education, Advocacy, and Specialty Recognition, the strongest thread was **not** that IH is under-recognized within ASMBS, but that IH must **more** intentionally articulate why its contributions and membership are valuable. The need is to clarify IH’s unique value proposition for members, prospective members, and external stakeholders.

Patterns include:

- Members don’t know what benefits exist (Pillar 1).
- Clinicians outside bariatrics do not see ASMBS as a multidisciplinary home (Pillar 1).
- State chapters do not consistently include IH in leadership (Pillar 3).
- Messaging across channels is fragmented (Pillars 2, 5).

This directly aligns with historical strategic objectives calling for IH to be the recognized authority on the multidisciplinary model (2014, 2015) and to increase **the value of membership** (2014, 2021–2025).

Education Is the Engine for Membership, Identity, Revenue, & Access

Every pillar connects back to education:

- Membership sees CE and learning pathways as the #1 recruitment driver.
- Joint accreditation unlocks universal CE and new instructional formats (Pillar 2).
- Certificates and micro-credentials tied to CBN accreditation create non-dues revenue (Pillar 5).
- State chapters rely on turnkey education to function and meet regulatory expectations (Pillar 3).
- Leadership development requires training pathways and transparent “how-to” curriculum (Pillar 4).

IH has always defined education as core, from Clinical Guidelines (2014, 2015) to professional development and competency-based systems (2021–22) to the 2025 emphasis on IH as a leading resource.

The **new Programmatic Model** integrates these elements into one system.

EXECUTIVE SUMMARY: Cross-Pillar Insights

Governance, Structure & Role Clarity Are Universal Pain Points

Leadership, committee operations, membership processes, and state chapter functions all share the same gaps:

- Lack of role clarity (IHLC, committees, speakers).
- Inconsistent onboarding and expectations.
- Variable committee responsiveness and execution.
- No systematic leadership pipeline.
- Need for IH parity at the state level.
- Need for compliance structures (state governance, membership processes).

These issues appear throughout all historical plans but **not** codified into a unified solution.

The 2025 analysis identifies leadership development, expectations, and accountability as core operating infrastructure, not optional tasks.

Infrastructure Modernization Determines Future Success

Across Pillars, technology and systems modernization are essential:

- AMS → membership automation, communities, segmentation
- LMS → CE automation, structured pathways, micro-learning
- Communication systems → cross-channel alignment
- Digital access → state chapters, advocacy, consumer/patient education
- Credentialing systems → certificate pathways

Every historical plan calls for better systems, but 2025 is the first time the infrastructure exists to actually support the work.

IHLC Must Become a Portfolio Manager, Not a Project Generator

All pillars emphasize execution uncertainty:

- “We get to the gate but stumble before the first turn.” (Pillar 1)
- Projects stall waiting on unclear next steps (Pillars 2, 4).
- State chapters lack structure and follow-through (Pillar 3).
- Great ideas pile up without ownership or timelines (all pillars).

The strategic programs of work solve this by:

- Defining annual, repeatable program areas
- Assigning ownership
- Allowing presidential priorities to plug into workstreams
- Creating annual success metrics
- Aligning committees under IHLC guidance

EXECUTIVE SUMMARY: Cross-Pillar Theme Matrix

Cross-Cutting Theme	Pillar Evidence (2025 Report)	Historical IH Strategy Alignment (2014-2025)
Value Proposition & Visibility Gaps	Membership value unclear; ASMBS perceived as “surgical only”; lack of IH visibility across channels.	2014 & 2015: Increase awareness of IH role; improve communications; raise visibility on website.
Education as Core Driver	Need for rapid content; joint accreditation; pathways; state education models.	2014–2025: Clinical guidelines, CE, multidisciplinary education emphasized in all plans.
Leadership Pipeline & Governance Structure Weakness	Term limits unenforced; unclear roles; inconsistent committee operations; need for mentorship.	2014 & 2021–22: Leadership development, job descriptions, mentorship pool.
Need for Speed & Execution Discipline	Lag in launching programs; slow content approvals; project bottlenecks; stalling.	2021–22: Call for defined timelines, project tracking, success metrics.
State Chapters as Weakest Link in Comprehensive Care	Variability, lack of IH parity, governance inconsistencies, lack of training and support.	2014 & 2015: State access initiatives (STAR), promote consistency across IH care.
Technology as a Catalyst	AMS will transform directories & communication; LMS integration; digital-first strategies.	2021–22 & 2025: Emphasis on modernizing infrastructure.
Multidisciplinary Identity Must Be Explicit	Need for clearer articulation of ASMBS as a multidisciplinary home for IH professionals.	2014–present: Core mission has always been “integrated multidisciplinary approach.”
Innovation Requires Product Development	Certificates, microlearning, GLP-1 resources, & branded tools.	2014–2025: CBN expansion, credentialing exploration, best practice tools.
Communication Gaps Create Missed Opportunities	Members unaware of processes, tools, content, or resources; inconsistent cross-promotion.	2014, 2015, 2021–22: All cite communication as a core deficiency.
Need for Non-Member Voice & External Market Alignment	Missing data on why non-members don’t join; need to reach PCPs, med-spa prescribers, residents.	Earlier plans focused internally; 2025 marks shift to outward-facing strategy.



EXECUTIVE SUMMARY

What This Means for IHLC in 2026-2028

The unified analysis clearly signals that future IH success depends on programmatic—not tactical—execution, sustained through:

- Annualized portfolios of work, **rather than** episodic initiatives
- Aligned leadership structures (IHLC → Committees → State Chapters)
- Modern systems supporting membership, education, credentialing, and communications
- Consistent messaging and branding as the multidisciplinary authority
- Data-informed decision-making, including non-member insights
- Strong governance and leadership pipelines

This cross-pillar synthesis provides IHLC with a high-level lens to prioritize presidential initiatives, measure progress annually, and ensure IH remains adaptable, influential, and mission-driven.

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Introduction

The Integrated Health Leadership Council (IHLC) convened for a working session designed to redefine how the Integrated Health (IH) Section approaches strategy and organizational alignment within ASMBS. This meeting intentionally departed from the traditional model of producing multi-year, static strategic plans and instead embraced a more flexible, **mission-driven** framework. This shift reflects the Society's broader movement toward adaptive planning models that allow for innovation, rapid response, and alignment across committees, councils, and leadership structures.

At the outset, participants were asked to engage in an open, candid conversation rather than a presentation-heavy or directive meeting format. The session was structured to be 99% conversation, with contributions recorded only to support the development of a thematic analysis—not to attribute comments to individuals. This approach encouraged honest reflection on challenges, opportunities, and the current state of IH work, while reinforcing the idea that all voices are equally important in shaping the future of the IH Section.

The purpose of structuring the meeting in this way was twofold. First, it acknowledged the limitations of rigid five-year strategic plans, which often become outdated or restrictive in rapidly changing environments. **For example**, no organization could have predicted the disruptions of the COVID-19 pandemic or the accelerated shifts in workforce models, education delivery, and **expectations in** patient care that followed. A flexible program-of-work model ensures IH remains responsive, relevant, and aligned with real-world conditions.

Second, the conversation was intentionally grounded in data-informed decision-making. Key findings from the IH member survey highlighting motivators such as education, networking, and advocacy, along with challenges around website usability, leadership development, hybrid learning, and member engagement, served as foundational inputs.

These insights informed the five strategic pillars framing the discussion and ensured alignment with the broader ASMBS mission, vision, and organizational priorities.

Participants were asked to respond to core questions within each pillar:

- What does success look like?
- What challenges must be addressed?
- What partnerships or resources will be needed?
- Who should lead and be accountable?

This structure encouraged the group to think beyond individual committees and instead consider IH work as part of an integrated, society-wide ecosystem—reflecting the long-standing goals documented in previous IH strategic plans from 2014, 2015, 2021–2022, and the evolving 2025 framework.

The following report distills the **group** discussion into a thematic analysis that identifies cross-cutting themes, points of alignment, structural opportunities, and recommendations for the IH Strategic Programs of Work. This analysis is intended to guide the next phase of IH leadership—ensuring cohesion across committees, supporting member value, and elevating the voice and impact of Integrated Health within ASMBS and across the field of obesity care.

IH Pillars Align to Comprehensive ASMBS Initiatives

Pillar 1 **Membership Value & Retention**

Pillar 2 **Education & Professional Development**

Pillar 3 **Speciality Recognition & Comprehensive Care**

Pillar 4 **Leadership & Mentorship Development**

Pillar 5 **Innovation, Revenue & Access**

Pillar 1: Membership Value & Retention

Purpose & Context

This analysis synthesizes the Integrated Health Leadership Council's discussion on Membership Value & Retention, with a focus on:

- What success by 2028 could look like for IH membership
- Core themes shaping value, recruitment, and retention.
- Outliers and friction points that could undermine growth.
- Recommended priority programs of work for IHLC (vs. one-off tactics).

These findings align directly with ASMBS IH's long-standing objectives around member value, retention, and cultivating a knowledgeable, empowered membership.

Pillar 1: Membership Value & Retention

High-Level Summary

Across the conversation, several strong themes emerged:

1. **Value ≠ Clear:** Members and non-members do not fully understand what they get from IH/ASMBS, and existing benefits are undercommunicated.
2. **Education is the “Hook,” Community is the “Glue”:** CE/CME and structured learning pathways attract people; peer connection and mentorship keep them.
3. **Brand & Perception Gap:** ASMBS is still widely perceived as “just a surgical society,” not the interdisciplinary, multimodal home for obesity care.
4. **Discipline-Specific Needs (Especially Coordinators & RDNs):** Different disciplines want different things; coordinators and dietitians are high-need/high-potential segments.
5. **Barriers to Joining:** Money, Time, and Process: Cost, employer support, generational attitudes, and the application/letter of recommendation process can create barriers to joining.
6. **Non-Member Voice is Missing:** Most insights come from existing members; there is little systematic understanding of why non-members do not join.
7. **Infrastructure & Communication Lag:** Technology (AMS, LMS, online communities) and social media processes are not yet nimble enough for how newer professionals engage.
8. **State/Regional & International Opportunities:** There is interest in using state chapters, regional events, and international connections as on-ramps to membership, but execution is uneven.
9. **Execution Gap:** Many good ideas stall “at the gate” and do not become sustained, visible programs of work.

Pillar 1: Membership Value & Retention

Thematic Analysis: Membership Value & Retention

Theme 1: Membership Value is Under-Communicated

What Surfaced

- Existing benefits have not significantly changed “in 17 years,” and many members are unaware of what already exists.
- Welcome letters/emails are being refined, but these are still basic one-way communications.
- There is a strong appetite for clear “value of membership” one-pagers and leadership-signed justification letters members can take back to employers.
- There was discussion of membership preview/trial models and discounts for lapsed/non-members.

Interpretation

- IHLC has historically set a goal to “define the value of membership for each discipline and develop marketing strategies” and, more recently, to “increase the value of membership for IH professionals at every stage of their careers”, but this is not yet consistently visible at the member level.
- The gap is less about inventing more benefits and more about packaging, messaging, and easy tools that members can use with their leadership and finance teams.

Implication

- IHLC should treat “Value Proposition & Justification Tools” as a core program of work rather than a one-off document.

Pillar 1: Membership Value & Retention

Theme 2: Education as Primary Driver

What Surfaced

- Many see CE/CME and online learning as the primary reason people initially join.
- Positive comparisons were made to organizations that offer tiered, structured learning pathways (“Introduction”, “Intermediate”, “Step 1–2–3” courses).
- Members want more free or low-cost online education, especially for those who cannot travel to conferences.
- There is interest in quick guides, toolkits, and content on unknown pathways (e.g., GLP-1 + surgery nutrition, evolving standards where guidelines are thin).

Interpretation

- This aligns closely with IH objectives to serve as a leading resource for standards and evidence-based education, as well as with the need for the Program Committee to fill education gaps with competency-based offerings.
- The unmet need is curated, staged learning paths by discipline and career stage, not just a catalog of sessions.

Implication

- A “Membership Learning Pathways” program (with clear levels and discipline-specific tracks) could be a flagship member benefit and a central retention tool.

Pillar 1: Membership Value & Retention

Theme 3: ASMBS Perception – “Just a Surgical Society”

What Surfaced

- Repeated concern that students and IH professionals know other obesity organizations, but do not think of ASMBS as a natural home because it’s perceived as surgeons-only.
- Participants want ASMBS to be the first organization people think of for obesity treatment across disciplines—a one-stop, interdisciplinary home.
- There is frustration that dietitians and weight-management professionals working full-time in bariatrics don’t know what ASMBS is, or assume it’s irrelevant to them.

Interpretation

- This directly conflicts with IH’s long-standing mission to “increase awareness of the importance of the integrated multidisciplinary approach” and the updated 2025 objective to position IH as a leading resource for multidisciplinary obesity care.

Implication

- IHLC should lead a positioning and messaging initiative (in partnership with surgeons and the Communications Committee) that explicitly markets ASMBS as the multidisciplinary home for obesity care, not just surgery.

Pillar 1: Membership Value & Retention

Theme 4: Discipline-Specific Needs

What Surfaced

- Strong consensus that different disciplines value different things:
 - Coordinators: processes, program operations, compliance
 - Dietitians: quick resources, practice guidance, GLP-1/surgery interface, and a dedicated “hub.”
 - Behavioral health, APPs, etc., each has distinct needs.
- Coordinators are described as highly engaged, high-volume members (e.g., highly active on Facebook, always asking “What do I do?”), but lack tailored structures—suggestions included a Coordinator Committee.
- The new RDN Committee and APP credentialing efforts were seen as exciting opportunities, but need more visible benefits/marketing.

Interpretation

- The strategic plans already emphasize discipline, inclusivity, and the cultivation of a knowledgeable, empowered membership across specialties. The 2025 update explicitly calls out new discipline-based committees (e.g., the Registered Dietitian & Nutrition Committee and the APP Committee).
- The discussion suggests that IHLC has started building the structure (committees) but now needs to translate those structures into visible, discipline-specific member value.

Implication

- IHLC should sponsor discipline-specific “value packages” that bundle education, community, and tools tailored to each group.

Pillar 1: Membership Value & Retention

Theme 5: Barriers to Joining and Renewing

What Surfaced

- Cost and lack of employer reimbursement are significant barriers—particularly for integrated health members with limited CME/education budgets.
- Younger clinicians and bedside staff are less inclined to join professional organizations; they don't see community networking as a core value, especially when working 12-hour shifts.
- The letter of recommendation/application process was repeatedly cited as a deterrent, especially for IH professionals. One participant delayed joining for 2 years due to the letter requirements.
- Complexity in qualifying sponsors and the perception that letters are “pointless if you don't know the person” adds friction without clear benefit.

Interpretation

- This contradicts IH's explicit goal of increasing membership value and retention, and of making membership accessible to new generations.
- There is a mismatch between risk-management instincts (letters to prevent inappropriate applicants) and growth/DEI instincts (lower barriers to entry, especially for IH disciplines).

Implication

- IHLC should lead a Membership Access & Policy Review to:
 - Modernize the application process (especially for IH categories).
 - Consider reducing or eliminating letter requirements for IH applicants.
 - Explore targeted pricing/discounts or “trial periods” for non-members and for those without employer support.

Pillar 1: Membership Value & Retention

Theme 6: Missing Voice of the Non-Member

What Surfaced

- Surveys have focused on current members, with questions like “What do you value?”
- Multiple people pushed for input from non-members: why they aren’t joining, what they would need to see, and how they perceive ASMBS.
- Ideas included:
 - Simple, anonymous interviews of non-member colleagues, possibly with incentives (e.g., win an ASMBS t-shirt).
 - Clinic-level micro-surveys targeting staff who work in bariatrics but don’t belong to ASMBS.

Interpretation

- Current strategies risk confirmation bias: we keep optimizing for people who already value the organization, not those we most need to reach.
- IH’s “member-focused” objective is incomplete without a systematic “voice of the non-member” program.

Implication

- IHLC should charter a Non-Member Insights Initiative as a defined program, feeding directly into membership strategy and product design.

Pillar 1: Membership Value & Retention

Theme 7: Infrastructure & Communication

What Surfaced

- Repeated frustration that good content takes months to move through approval and posting pipelines; this is incompatible with how younger professionals consume information and social media.
- There is interest in TikTok, short-form content, and quick reactions to emerging topics, but processes are slow and layered.
- The new Association Management System (AMS) and future community platform were described as game-changers—allowing:
 - Member communities by discipline.
 - Easier member-to-member contact (opt-out rather than opt-in).
 - Better directories and more visibility into who is new/and where.
- Some members are not aware of existing tools (e.g., “Find a Provider” doubles as a member directory once logged in).

Interpretation

- The 2021–22 and 2025 plans both emphasize building infrastructure that supports collaboration, communication, and member experience.
- IHLC is in a transition phase: many structural fixes are underway (AMS, app, communities), but not yet widely known or fully leveraged.

Implication

- IHLC should explicitly frame “Digital Member Experience” as a strategic program, with IHLC at the table as user-champions, not just passive recipients of IT work.

Pillar 1: Membership Value & Retention

Theme 8: State & International Channels as Membership On-Ramps

What Surfaced

- Interest in regional events and state chapters as ways to “meet people where they are,” particularly where state chapters are weak or struggling.
- New England and other regions were cited as examples of areas where greater state chapter engagement could unlock greater IH involvement.
- International connections (e.g., Peru) and the broader international program were flagged as future growth opportunities.

Interpretation

- This aligns with operating principles to “make an impact” and “build relationships”, as well as the 2025 emphasis on advocacy and international growth.
- State and regional activities can serve as “top of funnel” for IH membership if the connection to membership is intentionally designed (not assumed).

Implication

- IHLC should formalize a State/Regional Engagement Program with clear handoffs between state chapters, IH leadership, and the Membership Committee.

Pillar 1: Membership Value & Retention

Theme 9: Execution & Follow-Through Gaps

What Surfaced

- Several examples where IH starts strong but momentum fades:
 - Membership initiatives that never fully launch.
 - Requests for data (e.g., US-MBs metrics) with limited follow-through and unclear outcomes.
 - Good ideas (e.g., coordinator resources, non-member outreach) that stall due to a lack of a clear owner or process.
- Recurrent phrase: “We get to the gate but stumble before the first turn.”

Interpretation

- IHLC has already recognized the need for clear project pathways, tracking, and success metrics in its strategic plan, but this remains a pain point in practice.
- Without a programmatic approach, membership work will remain episodic and fragile.

Implication

- IHLC should treat “Membership Programs of Work” as a portfolio with owners, timelines, and defined outcomes, not as disconnected tasks.

Pillar 1: Membership Value & Retention

Outliers & Notable Ideas

A few ideas stood out as either disruptive or requiring deliberate policy decisions:

Membership Preview / Free Trial

Comparisons to subscription services and suggestions of 3-month trial memberships for non-members. This could increase conversion, but needs policy, financial, and system review.

Significant Simplification of IH Membership Requirements

Strong push to drop letters of recommendation for IH members, relying instead on CV/resume and practice description—even while recognizing that physician organizations often retain letters. This is a strategic decision about whom ASMBS wants to be accessible to, and how quickly.

Discipline-Based Committees Expansion (e.g., Coordinator Committee)

Creating new committees (as was done for RDs and APPs) would acknowledge the central role of coordinators but would also increase governance complexity and resource requirements.

Generational Mindset Gap

Acknowledgement that younger clinicians may not value traditional organizational engagement models. This isn't just a communication issue; it may require a different product design: shorter commitments, micro-volunteering, gamified learning, and always-on digital communities.

Pillar 1: Membership Value & Retention

Recommended Strategic Programs of Work

Strategic Programs of Work

Based on the themes, here are five concrete programs of work where IHLC should concentrate its effort over the next 2–3 years. Each can be aligned with presidential initiatives and tracked annually.

1. IH Value Toolkit
2. Learning Pathways & Discipline Hubs
3. Multidisciplinary Value Messaging Strategy
4. Membership Access & Policy Modernization
5. Non-Member Insights & Young Professional Engagement

Program 1: IH Membership Value Toolkit

Goal: Make the value of IH membership obvious, defensible, and easy to communicate.

Key elements

- Discipline-specific “Value of Membership” one-pagers (coordinators, RDs, APPs, BH, support group leaders, etc.).
- Standardized justification letters (membership and meeting attendance) co-signed by the ASMBS President & IH leadership.
- Short video explainer and micro-graphics for social media.
- Annual refresh tied to new initiatives and benefits.

Primary owners:

- Membership Committee (IH subcommittee)
- Communications Committee (IH subcommittee)

Pillar 1: Membership Value & Retention

Program 2: Learning Pathways & Discipline Hubs

Goal: Use education as the primary driver of recruitment and retention.

Key elements

- Create tiered learning paths (Intro/Intermediate/Advanced) for major disciplines within the LMS.
- Align sessions at the Annual Meeting and the ASMBS Weekend to these pathways, with clear symbols/labels.
- Build discipline hubs (starting with coordinators & RDs) that combine:
 - Pathway-linked content
 - Quick guides and toolkits
 - Office-ready resources (e.g., templates, patient handouts).
- Integrate free/discounted online CE as a core member benefit.

Primary owners:

- Program Committee
- Membership Committee (IH subcommittee)
- Communications Committee (IH subcommittee)

Pillar 1: Membership Value & Retention

Program 3: Multidisciplinary Value Messaging Strategy

Goal: Clearly communicate the value of ASMBS as a multidisciplinary professional home for all members of the obesity care team.

Key elements

- Clear message platform: what the multidisciplinary team looks like, and what each discipline contributes.
- Co-branded campaigns with surgeons that showcase team-based care.
- Outreach to academic programs (nursing, dietetics, psychology, APP programs) with:
 - Dedicated slides
 - Faculty toolkits
 - Student membership information.
- Highlight IH leadership and committee work in public-facing and member-facing communications.

Primary owners:

- IHLC
- Communications Committee, with touchpoints to APP/RDN/Support Group committees.

Pillar 1: Membership Value & Retention

Program 4: Membership Access & Policy Modernization

Goal: Lower unnecessary barriers while maintaining professional standards.

Key elements

- Review IH membership categories and streamline application requirements:
 - Consider removing or modifying letter requirements for IH categories.
 - Clarify and simplify sponsor requirements where letters remain necessary.
- Explore targeted pricing pilots:
 - Discounted first-year membership for qualifying non-members.
 - State-chapter or regional event bundles that include a membership component.
- Make “if you don’t have a sponsor, contact the office” messaging much more visible.

Primary owners:

- Membership Committee (IH subcommittee)
- IHLC, coordinating with HQ and surgeon leadership for policy approval.

Pillar 1: Membership Value & Retention

Program 5: Non-Member Insights & Young Professional Engagement

Goal: Understand and design for the people who are not already at the table—especially early-career professionals.

Key elements

- Design a simple non-member insights campaign:
 - Micro-survey template or brief interview script members can use with non-member colleagues.
 - Incentives (e.g., swag, recognition).
- Analyze findings and translate into concrete membership experiments (e.g., micro-volunteering, shorter terms, social-first opportunities).
- Pair with a social-media-first engagement strategy (quicker approval pipelines for TikToks, reels, quick “Did You Know?” content).

Primary owners:

- Membership (IH subcommittee)
- Communications (IH subcommittee)
- “Young Professionals” working group (could be a sub-group under IHLC).

Pillar 1: Membership Value & Retention

What Success Could Look Like By 2028

Drawing from the discussion and IH strategic objectives, a 2028 success picture for IHLC on membership might include:

- Higher, more stable IH membership with clear growth in target segments (coordinators, RDs, APPs, BH, early-career professionals).
- Improved renewal curves (higher early renewal percentages, fewer last-minute renewals).
- Clear evidence that members know and use their benefits (LMS engagement, downloads of toolkits, participation in discipline hubs).
- Recognition among students and early-career clinicians that ASMBS is the interdisciplinary home for obesity care.
- A functioning AMS-based community environment with active discipline-specific groups.
- A repeatable membership programs portfolio—with IHLC able to report annually on progress for each program of work.

Pillar 2: Education & Professional Development

Purpose & Context

This analysis synthesizes the Integrated Health Leadership Council's discussion on Education & Professional Development, with emphasis on:

- What IH education should evolve into over the next 1–3 years
- Barriers slowing down innovation
- Structural changes (CME, AMS, committee realignment) that transform what is possible
- Where IHLC should concentrate its efforts to create strategic, sustainable programs of work

This theme connects directly to long-standing IH priorities around professional development, competency-based education, and interdisciplinary collaboration and aligns with the updated 2025 strategic focus on advancing IH expertise, strengthening education pathways, and expanding multidisciplinary learning opportunities.

Pillar 2: Education & Professional Development

High-Level Summary

The discussion revealed several strong and consistent themes:

1. **Need for speed and nimbleness:** Education must move faster—micro-learning, rapid-turnaround content, nimble approvals.
2. **Joint accreditation is a game-changer:** The move to Joint Providership (JAC™) opens the door to universal CE for all disciplines—dietitians, nurses, psychologists, exercise physiologists, etc. This fundamentally reshapes what IH education can be.
3. **Governance structure changes were intentional:** Collaborative committees, unified program development, and cross-disciplinary leadership are necessary for compliance and cultural change.
4. **The culture shift toward surgeon-IH collaboration is real but still evolving.**
5. **IH needs turnkey offerings:** Quick, scalable content packages, fundamental courses, Q&A sessions, and plug-and-play state chapter resources.
6. **State chapters represent a significant education opportunity—but are inconsistent.**
7. **Partnerships with other organizations and industry are underutilized—but represent significant growth potential.**
8. **Technology backbone (LMS, CE reporting, AMS) is aligning—enabling growth that was not possible before.**
9. **Communication gaps persist:** Members do not know what happens behind the scenes or why processes take so long.

Pillar 2: Education & Professional Development

Thematic Analysis: Education & Professional Development

Theme 1: A Need for Speed

What Surfaced

- Education programs currently take too long to build; many initiatives stall for months or years.
- Strong call for micro-learnings, quick-turn modules, and non-CE content that can be deployed immediately.
- IH wants the flexibility to partner with other groups or rapidly create internal content.

Interpretation

- IH has been constrained by old processes, committee isolation, and compliance requirements that were not aligned with multidisciplinary education.
- With new systems and joint accreditation, IH can deliver real-time, agile education, which the membership (especially younger clinicians) expects.

Implication

IHLC should prioritize a Rapid Education Model, with:

- 5–10 minute micro-learnings
- Quick-turn topic briefs (“GLP-1 + Surgery Nutrition Updates,” “Comorbidity Snapshot”)
- Non-CE modules deployable in under 30 days
- A clear pathway for fast approvals

Pillar 2: Education & Professional Development

Theme 2: Joint Accreditation Transforms the Landscape

What Surfaced

- ASMBS is working towards Joint Providership, enabling universal CE/CME:
 - Dietitians
 - Nurses
 - Behavioral health
 - Exercise professionals
 - Physicians
- Joint accreditation requires documented collaboration between MD and IH leaders.
- Governance restructuring (IH co-chairs, collaborative committees) was deliberately designed to meet accreditation standards—not arbitrarily.

Interpretation

- Joint accreditation is structural and strategic, not administrative.
- It forces multidisciplinary planning and eliminates historic silos.
- This is one of the most impactful IH developments in more than a decade.

Implication

- IHLC should anchor its education strategy around the unified CE ecosystem, including:
 - Discipline-specific CE pathways
 - Reporting automation via LMS
 - Compliance-first workflow templates for committees
 - Raising awareness—most IH members do not yet understand this major shift

Pillar 2: Education & Professional Development

Theme 3: Governance Evolution Enables Better Education

What surfaced

- Program Committees historically worked in silos; IH and surgeons had completely different approaches to program building.
- Surgeons often did not meet regularly; IH met monthly.
- Directors did not always involve all speakers or disciplines; many sessions lacked true collaborative design.
- IH roles (co-chair, program leadership) are now required for accreditation compliance.

Interpretation

- The governance reforms (collaborative committee, IH co-chairs, required joint planning) are enabling education that reflects the real multidisciplinary care model, not parallel tracks.
- This is a culture change, especially for IH—but momentum is positive.

Implication

- IHLC should help codify:
 - Expectations for collaborative program planning
 - Standardized procedures and timelines
 - Orientation for incoming IH program leaders
 - Annual training on accreditation and compliance

Pillar 2: Education & Professional Development

Theme 4: Surgeon & IH Collaboration is Improving

What Surfaced

- Many were initially skeptical of the combined program committee, but now report stronger collaboration, more respectful interactions, and more IH inclusion.
- Surgeons are demonstrating a willingness to change long-standing habits (e.g., meeting frequency, speaker engagement, co-planning).

Interpretation

- A genuine cultural transformation is happening—but it requires continued reinforcement.
- Leadership is aligned, and collaboration is mandatory.

Implication

- IHLC should support IH Program Leaders by encouraging:
 - Surgeon–IH equity
 - Shared decision-making
 - Joint leadership visibility
 - Celebration of collaborative wins

Pillar 2: Education & Professional Development

Theme 5: Turnkey Education for Members & State Chapters

What Surfaced

- States vary wildly in organization, engagement, and competency.
- Many cannot offer CE easily or afford recording and editing.
- Members want access to national content, state versions, and flexible delivery formats.
- Ideas included:
 - State chapter packages
 - Group licensing
 - Deeply discounted recording bundles
 - Quarterly Q&A add-ons to fundamental courses

Interpretation

- State chapters represent a high-leverage distribution channel for IH education.
- But National currently has no consistent system to support them and no ability to enforce accountability.

Implication

- IHLC could assist a State Education Partnership Program, including:
 - Turnkey CE packages for states
 - “Pick-up-and-go” recorded content
 - Templates for agendas, speaker outlines, and documentation
 - Guidance for compliance reporting
 - (Long-term) clearer standards for state chapter expectations

Pillar 2: Education & Professional Development

Theme 6: Partnership Potential – Internal & External

What Surfaced

- IH sees potential opportunities to collaborate with:
 - OMA
 - TOS
 - Catalyst / global obesity organizations
 - Industry partners (e.g., Eli Lilly)
 - International credentialing and dietetics bodies
- IH wants:
 - Cross-promotional CE
 - Shared content
 - Reciprocal discounts
 - Co-branded micro-learning packages
 - Alignment with patient education standards

Interpretation

- Partnerships could dramatically expand reach, revenue, and influence, but no formal architecture exists yet.

Implication

- IHLC could sponsor a Professional Alliances & Partnerships Program, with:
 - MOUs
 - Co-developed educational bundles
 - Joint webinars
 - Topic-specific microsessions
 - Annual partner engagement calendar

Pillar 2: Education & Professional Development

Theme 7: Technology Backbone Enables Scalability

What Surfaced

- LMS now supports CE auto-reporting.
- AMS (in development) will create communities, member directories, and tracking needed for accreditation.
- Compliance failures could “break the whole cycle.”
- Members lack understanding of how complex and interdependent the systems are.

Interpretation

- ASMBS is now at a stage where its digital infrastructure can support a modern educational strategy.
- The next year is about turning capability into user-facing products.

Implication

- IHLC should shape a Digital Education Experience Roadmap, including:
 - LMS restructuring (pathways, competency tracks, discipline hubs)
 - Auto-enrollment for new-member learning sequences
 - Micro-learning galleries
 - CE dashboards for members

Pillar 2: Education & Professional Development

Theme 8: Communication Gaps

What Surfaced

- Many in the room said, “We didn’t know any of this was happening behind the scenes.”
- Members don’t understand:
 - Why sessions must be structured a certain way
 - Why MD/IH representation is mandated
 - Why approval takes time
 - Why certain governance changes were made
 - How CE gets accredited

Interpretation

- IHLC must own a more transparent communication model.
- Without visibility, members confuse necessary compliance steps with bureaucracy.

Implication

- IHLC should launch a “How Education Works at ASMBS” Transparency Initiative, with:
 - Short videos explaining accreditation
 - Flowcharts for program development
 - Quarterly member updates
 - Behind-the-scenes features

Pillar 2: Education & Professional Development

Outliers & Notable Ideas

These ideas surfaced as either disruptive or requiring strategic decision-making:

Quarterly live Q&A add-ons for fundamentals courses—a hybrid model blending asynchronous content with real-time community engagement.

Alliance Program—multi-year strategic partnerships that integrate educational exchange, content-sharing, and certificates.

Bundled state chapter licensing—allowing states to purchase access to curated educational packages.

International CE reciprocity—offering CDR credits to international dietitians through ASMBS programming.

Microlearning "package drops"—curated bundles for rapid deployment on hot topics (GLP-1, complications, comorbidity management, etc.).

Enforcement of state chapter accountability—a long-term governance consideration that could enable consistent educational delivery.

Pillar 2: Education & Professional Development

Strategic Programs of Work

Based on the themes, here are five concrete programs of work where IHLC should concentrate its effort over the next 2–3 years. Each can be aligned with the ASMBS presidential initiatives and the IHLC director initiatives and tracked annually.

1. Rapid Education Development & Micro-Learning Engine
2. Joint Accreditation Integration & Multidisciplinary CE Pathways
3. Collaborative Program Governance & Leadership Development
4. State Chapter Education Partnership Initiative
5. Professional Alliances & Strategic Partnerships
6. Transparency & Member Education About “How ASMBS Education Works”

Program 1: Rapid Education & Micro-Learning Engine

Goal: Deliver timely, high-impact education at the speed members actually practice—shifting from slow, one-off programs to an ongoing stream of nimble, needs-based content.

Key Elements

- Create a micro-learning library (5–15 minute modules, videos, quick reads) on high-priority topics (e.g., GLP-1 + surgery, complications, comorbidities, program operations).
- Stand up a rapid-response workflow for “hot topics” (clear intake form, IHLC triage, streamlined content/approval steps).
- Develop non-CE quick content (tips, checklists, brief updates) that can be deployed without full accreditation requirements.
- Build a 12–18-month editorial calendar that aligns micro-learnings with conferences, guidelines, and advocacy priorities.
- Use the LMS to bundle micro-learnings into mini-series or playlists (e.g., “New Coordinator Essentials,” “Obesity Pharmacotherapy 101”).

Primary Owners

- Program & IH Subcommittee (lead)
- IHLC Education Workgroup
- Education/LMS Staff (operational support)

Pillar 2: Education & Professional Development

Program 2: Joint Accreditation & Multidisciplinary CE Pathways

Goal: Fully leverage joint accreditation to provide integrated CE/CME for all disciplines and make ASMBS the premier home for comprehensive, team-based obesity education.

Key Elements

- Design discipline-specific CE pathways (RD, RN, BH, APP, exercise, coordinators, surgeons) with clear entry, intermediate, and advanced levels.
- Ensure every major course under joint accreditation includes both MD and IH faculty to meet standards and model team-based care.
- Map existing LMS content to new pathways, re-authorizing CE where compliant, and sunseting what cannot be brought into the new structure.
- Build CE dashboards within the LMS so members can see credits, gaps, and recommended next steps by discipline.
- Create simple committee toolkits (checklists, templates) for planning CE-compliant sessions and documenting accreditation requirements.

Primary Owners

- Program & IH Subcommittee (lead)
- Accreditation/Joint Providership Lead/Education Staff

Pillar 2: Education & Professional Development

Program 3: Collaborative Governance & Leadership Development

Goal: Embed surgeon–IH collaboration in how all education is planned, approved, and delivered—while staying compliant with committee and accreditation standards.

Key Elements

- Formalize a joint Program Committee structure with:
 - Clearly defined surgeon and IH co-chair roles
 - At least quarterly joint meetings (not just email chains)
- Develop a Program Chair/Co-Chair onboarding (MD + IH) that covers:
 - Accreditation requirements
 - Expected timelines and workflows
 - How to build truly collaborative sessions
- Standardize a session director playbook (outlines, expected speaker engagement, timelines, example emails, and meeting templates).
- Build a continuity model so incoming co-chairs shadow outgoing leaders for at least one cycle.
- Track metrics: number of collaborative sessions, balance of disciplines in faculty, and program feedback.

Primary Owners

- Program Committee (Surgeon + IH Co-Chairs) (lead)
- Governance/Committee Operations Staff (structural and scheduling support)

Pillar 2: Education & Professional Development

Program 4: State Chapter Education Partnership Initiative

Goal: Equip state chapters—regardless of size or maturity—to deliver consistent, compliant, high-quality education that aligns with national priorities.

Key Elements

- Develop turnkey state education packages (e.g., 2–4-hour programs with slides, learning objectives, speaker notes, and evaluation tools).
- Offer discounted bundles of Annual Meeting recordings or topic-specific packages that states can use as the backbone of their meetings.
- Provide simple CE playbooks for states using ASMBS joint providership (what data we need, timelines, forms, and reporting expectations).
- Pilot state or regional access models (e.g., group rates, “state chapter bundle” pricing) to help members who cannot travel to national meetings.
- Build a feedback loop where high-performing state programs can share topics and models that may be elevated to national or used by other states.

Primary Owners

- State Chapter Committee (lead)
- Program Committee
- Program/State Chapter Staff
- IHLC

Pillar 2: Education & Professional Development

Program 5: Professional Alliances & Strategic Partnerships

Goal: Expand the reach, impact, and perceived value of ASMBS education through intentional alliances with professional societies and industry—while aligning with comprehensive care standards.

Key Elements

- Identify priority partner organizations (e.g., OMA, TOS, nursing and dietetics groups, international obesity societies), and map shared educational interests.
- Develop MOUs or partnership frameworks defining:
 - Co-branded or joint educational offerings
 - Reciprocal discounts or access to select LMS content
 - Expectations around messaging comprehensive care (not siloed surgery or meds alone)
 - Create co-branded micro-learning packages for external audiences that point back to ASMBS membership and longer-form learning.
- Work with industry partners (e.g., pharma) to support comprehensive-care education that:
 - Meets FDA and accreditation standards
 - Integrates surgery + pharmacotherapy + IH care
- Ensure all partnerships adhere to ASMBS ethics, conflict-of-interest, and accreditation rules.

Primary Owners

- IHLC (lead on IH-focused partnerships)
- ASMBS Executive Leadership (President/CEO)
- Corporate Council / Industry Relations
- Program Committee (for content oversight)

Pillar 2: Education & Professional Development

Program 6: Transparency & Education About Ecosystem

Goal: Increase member trust, engagement, and understanding by demystifying how ASMBS education is built, accredited, and delivered.

Key Elements

- Create short explainer videos and infographics on:
 - How joint accreditation works
 - Why IH and MD must both be at the table
 - Why timelines look the way they do
- Develop a visual “Education Pipeline” map from idea → committee → content creation → accreditation → LMS/posting.
- Publish quarterly “Education & CE Updates” (email or brief video) highlighting:
 - New courses and pathways
 - System upgrades (LMS, AMS)
 - Key process changes
- Present a brief “How Education Works” update at IHLC, state chapter meetings, and Annual Meeting (IH track).
- Provide committee-facing toolkits so leaders can explain these processes to their volunteers and keep expectations realistic.

Primary Owners

- Program Committee + IHLC (co-lead)
- Communications/Marketing Staff
- Education/Accreditation Staff

Pillar 2: Education & Professional Development

What Success Could Look Like By 2028

By 2028, ASMBS IH education should demonstrate:

- Rapid, high-quality, multidisciplinary content development that responds to clinical needs in real time.
- A fully leveraged joint accreditation structure, with accessible CE for every IH discipline.
- Clear, structured learning pathways, from fundamental to advanced levels.
- Strong state chapters delivering consistent, accredited education, supported by national turnkey content.
- High-impact partnerships amplifying ASMBS's influence nationally and internationally.
- A transparent, predictable, member-friendly education ecosystem where processes are understood and valued.
- Evidence of culture change—surgeons and IH designing programs together, routinely and seamlessly.

Pillar 3: Speciality Recognition & Comprehensive Care

Purpose & Context

This analysis synthesizes the Integrated Health Leadership Council's discussion on Specialty Recognition & Comprehensive Care, with a focus on:

- Ensuring consistency in how comprehensive bariatric/metabolic care is delivered and represented across states.
- Clarifying the role of state chapters in advocacy, access, and utilization of care.
- Operationalizing IH parity and protection at the grassroots level.
- Identifying where IHLC should concentrate its efforts to support state chapters and build a sustainable leadership pipeline.

The conversation made clear that specialty recognition and comprehensive care are not abstract; they are lived (or not) through state chapters, local advocacy, and multidisciplinary leadership.

Pillar 3: Speciality Recognition & Comprehensive Care

High-Level Summary

Across the discussion, key themes emerged:

1. **Grassroots is where specialty recognition becomes real:** State chapters are the frontline for advocacy, access, and utilization—and currently very inconsistent.
2. **IH parity is codified nationally but not guaranteed locally:** IH is protected in national bylaws, but state practices often lag behind.
3. **State chapters are highly variable and under-supported:** There are “haves” and “have-nots,” with big differences in structure, resources, and compliance.
4. **National has tools, but not yet a system:** Resources, request forms, and board support exist, but they’re not being consistently used, and accountability is weak.
5. **Need for state leadership training and mentorship:** Many state leaders want help but don’t know how to access it or how to run a chapter efficiently.
6. **Capacity and equity matter:** Some states have robust infrastructure (e.g., exec directors, strong finances); others have almost nothing.
7. **Leadership pipeline and succession planning:** Specialty recognition and comprehensive care depend on continuously refreshing leadership.

Pillar 3: Speciality Recognition & Comprehensive Care

Thematic Analysis: Speciality Recognition & Comprehensive Care

Theme 1: Grassroots State Infrastructure Drives Recognition

What Surfaced

- The group repeatedly linked this pillar to state-level work: recognition, consistent standards, advocacy, access to care, and utilization of care.
- Legislative and advocacy outcomes “happen at the state level”—that’s the grassroots.
- If grassroots work is weak or fragmented, efforts to improve access to care and specialty recognition will be undermined.

Interpretation

- Specialty recognition and comprehensive care depend on how well state chapters function, not just on national statements or guidelines.
- Strong state infrastructure is a prerequisite for effective advocacy and consistent, comprehensive care messaging.

Implication

- IHLC must treat state chapter strengthening as a core pillar of specialty recognition and comprehensive care, not as a side issue.

Pillar 3: Speciality Recognition & Comprehensive Care

Theme 2: IH Parity is Protected Nationally but Uneven Locally

What Surfaced

- National bylaws clearly protect IH as a distinct, equal membership category alongside MDs.
- IH status is now structurally embedded; it would require IH to “vote themselves out” to lose that protection.
- Participants questioned why state chapters are not held to similar expectations (e.g., IH presence on boards, IH involvement in planning).

Interpretation

- There is a clear mismatch: IH is recognized and protected nationally, yet in many states:
 - IH membership is tiny (e.g., “three integrated health members in our state chapter”).
 - IH is not consistently at the table or in leadership roles.
- This undermines the goal of comprehensive care and the credibility of specialty recognition claims.

Implication

- IHLC should champion IH parity at the state level as a standard—not optional—and collaborate with surgeon leadership to make it explicit and measurable.

Pillar 3: Speciality Recognition & Comprehensive Care

Theme 3: State Chapter Variability

What Surfaced

- Some state chapters run extremely well; others are barely functioning or non-existent.
- There are “haves” (large, well-resourced states like Texas, Florida) and “have-nots” with minimal membership, engagement, or structure.
- Compliance issues:
 - State members sometimes think paying state dues = national membership.
 - States may enroll people who are not eligible national members.
 - Cross-checking is honor-based, not systematic.

Interpretation

- Inconsistent state function and compliance erode brand consistency and threaten the integrity of specialty recognition.
- Without transparent reporting and accountability, the national cannot reliably claim that the ASMBS “ecosystem” is aligned with comprehensive, multidisciplinary standards.

Implication

- IHLC should support a State Chapter Governance & Compliance Framework that sets minimum expectations (reporting, national membership status, IH representation, basic activity levels).

Pillar 3: Speciality Recognition & Comprehensive Care

Theme 4: National Support Exists but is Underused

What Surfaced

- National has already created some support tools:
 - A request form for states to bring in national leaders/staff to speak (with board-approved funding).
 - Internal assets/templates Dr. Diane Enos has from previous work that could be adapted.
- Problems:
 - Not all states are aware of these resources.
 - Some bypass the system (by inviting board members directly rather than using national decks or scripts).
 - National sometimes learns about state activities only through social media.

Interpretation

- The issue is not only resource scarcity; it is also system design and communication.
- Without a straightforward, easy-to-use, visible pathway, states rely on informal networks and ad hoc requests, leading to uneven messaging and missed opportunities.

Implication

- IHLC should help design an “on-ramp” system for states: simple, well-communicated processes that make using national support the default rather than the exception.

Pillar 3: Speciality Recognition & Comprehensive Care

Theme 5: State Leadership Needs Training & Mentorship

What Surfaced

- Many state leaders want to do better but don't know how:
 - They ask basic “how do we?” questions without clear answers.
 - There's interest in mentorship, but no formal structure.
- Suggestions:
 - State leader training on how to run a chapter (budgeting, pricing meetings, overhead, scheduling, basic governance, and compliance).
 - Joint training that brings the surgeon and the IH state leaders together to model collaboration.
 - Using strong states as models and mentors for weaker ones.

Interpretation

- State leadership roles are often filled by well-meaning clinicians rather than trained association professionals.
- Specialty recognition depends on these leaders feeling equipped, not overwhelmed.

Implication

- IHLC should help build a State Chapter Leadership Mentorship & Training Program that addresses the “how” in a structured, repeatable way.

Pillar 3: Speciality Recognition & Comprehensive Care

Theme 6: Structural Governance Issues Impact Consistency

What Surfaced

- State chapters are separate legal entities (individual bylaws, 501(c) status), but they:
 - Still represent ASMBS and carry its name.
 - Must comply with national articles (e.g., state members must be active national members).
- Internally:
 - Historically, there were no term limits for committees, and leadership often stayed in place for years (sometimes personally funding activities).
 - There's recognition that term limits and leadership turnover are necessary to make room for new leaders.

Interpretation

- Governance (both national and state) directly affects how consistently the specialty is represented and how comprehensively care is delivered.
- A culture of personal heroics ("I fund the meeting myself") is not sustainable and undermines equity and consistency.

Implication

- IHLC should integrate governance best practices (term limits, pipelines, mentorship, basic accountability) into its specialty recognition and comprehensive care program of work.

Pillar 3: Speciality Recognition & Comprehensive Care

Theme 7: Capacity, Equity, and the “Haves vs. Have Nots”

What surfaced

- Some states have:
 - Executive directors or management companies.
 - Regular, robust, well-funded educational meetings.
- Others:
 - Struggle to fund basic activities.
 - Lack of admin capacity and knowledge (state tax filings, 501(c) compliance, meeting logistics).
- Ideas:
 - Seed funding, grants, or time-limited startup support from national.
 - A national staff person providing partial administrative support for multiple states.
 - Encouraging regional models where states band together if they cannot sustain standalone chapters.

Interpretation

- The inequity between states not only affects local members but also weakens society-wide claims for consistent, comprehensive care and specialty recognition.
- Without addressing resource gaps, weaker states will remain weak, and IH's presence will stay minimal.

Implication

- IHLC should support a State Capacity & Equity Initiative to address the structural disadvantages faced by smaller/weaker states.

Pillar 3: Speciality Recognition & Comprehensive Care

Outliers & Notable Ideas

A few ideas stood out as particularly notable or disruptive:

National “first-draft” toolkits: Rather than waiting on state chapter members to develop documents, national staff could provide ready-made templates (bylaws samples, budget templates, board decks, policies) for states to adapt.

Nationally provided admin support for states:

- A single staff role supporting many states for small monthly fees.
- A hybrid model in which national “gifts” set the time, and states later pay nominal amounts.

State seed grants/startup support:

- Small, time-limited boosts to help weaker states get organized, compliant, and functional.

Regionalization:

- Encouraging multi-state or regional chapters where individual states can't sustain a whole structure.

IH seat and active parity expectations on state boards:

- Moving from “nice to have” to an explicit expectation that states include IH in leadership.

These are not yet consensus positions but are high-leverage levers that IHLC may want to actively explore.

Pillar 3: Speciality Recognition & Comprehensive Care

Strategic Programs of Work

To strengthen specialty recognition and ensure consistent, multidisciplinary care across all states, IHLC must focus on improving the systems, support, and alignment that drive state chapter performance. Because state chapters are the frontline for ASMBS advocacy and public representation, these programs aim to create clarity, consistency, and stronger integration between national priorities and state-level implementation.

1. State Chapter Governance & Compliance Framework
2. IH Parity & Presence at the State Level
3. State Leadership Mentorship & Training Program
4. State Capacity & Equity Initiative
5. State–National Integration & Messaging for Comprehensive Care

Pillar 3: Speciality Recognition & Comprehensive Care

Program 1: State Chapter Governance & Compliance Framework

Goal

Ensure all state chapters operate in compliance with ASMBS standards, are consistent with them, and align with comprehensive, multidisciplinary care.

Key Elements

- Define minimum expectations for state chapters:
 - Annual reporting (activities, finances, membership)
 - Evidence of compliance with national articles (state members are active national members)
 - Basic governance standards (bylaws, elections, IH representation)
- Create template tools:
 - Bylaw models
 - Sample policies & procedures
 - Budgeting and meeting pricing calculators
 - State annual report template
- Implement a simple, phased compliance review cycle:
 - Start with education and support before penalties.
 - Clear timeline for when expectations become formal requirements.

Primary Owners

- State & Local Chapters Committee (lead)
- IHLC (to ensure IH standards and a comprehensive care lens)
- ASMBS Governance/State Chapters Staff (lead in collaboration with State & Local Chapters Committee)

Pillar 3: Speciality Recognition & Comprehensive Care

Program 2: IH Parity & Presence at the State Level

Goal

Translate national IH protection and parity into real-world practice by embedding IH representation in state chapter leadership and decision-making.

Key Elements

- Establish and communicate expectations that:
 - State chapter boards include IH representatives.
 - IH is involved in program planning and state-level advocacy activities.
- Use Access to Care and IHLC to:
 - Identify states with no or minimal IH presence.
 - Develop outreach strategies to recruit and support IH leaders.
- Include IH parity metrics in state annual reports:
 - Number of IH board members
 - IH membership counts
 - IH involvement in state education/advocacy efforts.

Primary Owners

- IHLC (lead for IH-related standards)
- State & Local Chapters Committee
- Access to Care Committee (alignment with advocacy/work)

Pillar 3: Speciality Recognition & Comprehensive Care

Program 3: State Leadership Mentorship & Training Program

Goal

Equip state leaders (surgeon and IH) with the skills, tools, and connections they need to run effective, sustainable chapters that reflect ASMBS specialty standards.

Key Elements

- Develop a state leader training curriculum:
 - Running effective meetings
 - Budgeting and pricing basics
 - 501(c) and state compliance basics
 - Leveraging national tools and staff
- Offer joint training for surgeon and IH state leaders, modeling the collaborative, comprehensive care approach.
- Create a mentorship network:
 - Pair strong states with emerging states.
 - Encourage peer consults and sharing of “what works.”
- Provide a State Leader Toolkit (digital binder) including:
 - Templates, checklists, timelines
 - Sample communications
 - Access pathways to national speakers and resources

Primary Owners

- State & Local Chapters Committee (lead)
- IHLC (to ensure IH involvement and content)
- ASMBS State Chapter/Education Staff

Pillar 3: Speciality Recognition & Comprehensive Care

Program 4: State Capacity & Equity Initiative

Goal

Reduce disparities between high-capacity and low-capacity state chapters so that comprehensive care and specialty recognition are not geography-dependent.

Key Elements

- Assess state capacity:
 - Financial health
 - Meeting frequency
 - Admin support (volunteer vs. paid)
 - IH membership and activity
- Pilot startup/seed support:
 - Time-limited administrative help from national
 - Small grants or in-kind support (e.g., staff support for filings, meeting setup)
- Develop a national admin support option:
 - One staff role provides limited hours to multiple states for modest fees.
 - Sliding scale based on state size and capacity.
- Explore regional models:
 - Encourage states with very limited capacity to form multi-state or regional structures.

Primary Owners

- IHLC & State & Local Chapters Committee (co-leads)
- ASMBS Executive Leadership & Finance (for funding/structure)
- Corporate/Development (if grants or external funding are needed)

Pillar 3: Speciality Recognition & Comprehensive Care

Program 5: State–National Integration & Messaging

Goal

Ensure that state-level activities consistently reinforce ASMBS's comprehensive, multidisciplinary specialty identity and connect back to national.

Key Elements

- Standardize board decks and messaging for national representatives speaking at state meetings:
 - Specialty recognition
 - Comprehensive care model (surgeon + IH)
 - Membership expectations and benefits.
- Make the state speaker request process:
 - Simple, prominent, and widely communicated.
 - The default pathway for inviting national leaders/staff.
- Develop feedback loops:
 - Gather quick reports from national speakers after state visits (themes, needs, successes).
 - Use those insights to refine support and resource development.
- Encourage consistent use of ASMBS branding and messaging so that the specialty is represented uniformly across states.

Primary Owners

- State & Local Chapters Committee & IHLC (co-leads on messaging and content)
- Executive Office

Pillar 3: Speciality Recognition & Comprehensive Care

What Success Could Look Like By 2028

By 2028, success for this pillar might look like:

- Every active state chapter has:
 - IH representation on its board.
 - Clear ties to national standards and messaging.
 - Basic governance and compliance are in place.
- Consistent comprehensive care messaging in state education and advocacy
- A functional support system where states:
 - Know how to request help.
 - Routinely use national templates and speaker resources.
 - Feel guided, not left on their own.
- Reduced disparity between “haves” and “have-nots” states, with concrete improvement in weaker states’ capacity.
- A visible leadership pipeline, with regular turnover in state roles and new IH leaders stepping into the spotlight.
- A credible external narrative that ASMBS is the recognized home of comprehensive obesity care, reflected not just in bylaws and national meetings, but in the daily work of state chapters across the country.

Pillar 4: Leadership & Mentor Development

Purpose & Context

This pillar focuses on how IHLC and ASMBS cultivate, support, and sustain leaders across committees, councils, state chapters, and program roles. The discussion surfaced both structural gaps (term limits, expectations, processes) and emotional realities (imposter syndrome, confusion, frustration) that impact whether talented people step up, stay engaged, and successfully grow into leadership.

Leadership & Mentor Development is therefore about more than titles: it is about creating a culture and system where leaders make space for others, new voices can see a path in, and everyone understands what it means to serve effectively.

Pillar 4: Leadership & Mentor Development

High-Level Summary

Key themes that emerged:

1. **Leadership as stewardship, not ownership:** Leaders must make space for those who come after them; term limits and succession are essential, not optional.
2. **Lack of role clarity:** Many leaders and IHLC members do not fully understand their responsibilities or what success looks like in their roles.
3. **Barriers to new voices:** Processes around speakers, committees, and leadership often default to “the same people,” making it hard for emerging leaders to break in.
4. **Mentorship is present but underpowered:** Buddy systems exist but lack structure, action, and clear goals.
5. **Committee processes are inconsistent:** Applications go unanswered; chairs respond slowly; expectations are not explicit.
6. **Accountability vs. volunteerism:** This is a volunteer organization, but one with serious responsibilities; expectations and follow-through are needed.
7. **Pipeline management is underdeveloped:** Candidates who run and are not elected, or who are interested but unsure where to start, are at risk of being lost.

Pillar 4: Leadership & Mentor Development

Thematic Analysis: Leadership & Mentor Development

Theme 1: Leadership as Making Space, Not Holding Space

What Surfaced

- Leaders were challenged to see their role as creating space for others rather than staying in positions indefinitely.
- Term limits had not historically been enforced, even though committees are supposed to have them.
- The idea that “someone made space for you to be in your seat” resonated with the group.
- Leaders were urged to ask themselves daily: “What am I doing to ensure this team succeeds if I’m not here?”
- The distinction was made between leading vs. managing: if no one is coming behind you, you’re managing, not leading.

Interpretation

- Leadership culture has historically been person-dependent rather than pipeline-dependent.
- There is an emerging shared belief that succession and mentorship are intrinsic to leadership, not optional add-ons
- Without term limits and explicit expectations, leadership roles can inadvertently become “owned” rather than stewarded.

Implication

- IHLC needs to embed a stewardship mindset into all leadership roles, supported by clear term limits and expectations that leaders will actively mentor and prepare successors.

Pillar 4: Leadership & Mentor Development

Theme 2: Missing Role Clarity and Onboarding

What Surfaced

- New IHLC members openly shared that they do not know what they are supposed to be doing.
- Some leaders described feeling “worthless” or like they “haven’t done anything” despite wanting to contribute.
- There is no central place where responsibilities, expectations, and success metrics are clearly laid out.
- Communication during transitions between outgoing and incoming leaders is highly variable.
- People noted that prior committee or leadership experience elsewhere makes this easier, but they cannot rely on that.

Interpretation

- Lack of standardized role descriptions and onboarding is a barrier to engagement and confidence.
- Leaders are wasting emotional energy feeling inadequate rather than being guided toward concrete contributions.
- The absence of clarity also weakens mentorship: mentors cannot meaningfully guide mentees without shared expectations.

Implication

- IHLC must prioritize clear, written role definitions and structured onboarding for IHLC members, committee chairs, and other key roles to reduce confusion and support effective leadership.

Pillar 4: Leadership & Mentor Development

Theme 3: Barriers to Bringing in New Speakers & Leaders

What Surfaced

- Concrete examples were shared of situations in which ideal new speakers (e.g., maternal health experts) could not be added due to perceived limits on funded speaker slots.
- Messages about whether additional speakers could be added were conflicting and changed over time.
- Participants agreed that having “the same people” speaking repeatedly is a frequent criticism.
- Speaker caps designed for budget control sometimes clash with the goal of refreshing the leadership pool.
- IHLC identified speaking roles as a critical gateway into higher leadership and visibility.

Interpretation

- There is a tension between financial constraints and pipeline development that has not been resolved in a transparent way.
- Confusion about rules and processes leads to missed opportunities to elevate new experts.
- Without intentional efforts to bring in new speakers, leadership remains concentrated among a small, familiar group.

Implication

- IHLC should work with program and finance leadership to create transparent, flexible policies that protect the budget while explicitly reserving space for emerging speakers and leaders.

Pillar 4: Leadership & Mentor Development

Theme 4: Mentorship Exists but Lacks Structure & Outcomes

What Surfaced

- A mentorship/buddy system has been established, but mentees report not knowing what to ask or what their goals should be.
- Mentorship interactions are often informal (texts, casual check-ins) and not clearly tied to action or opportunities.
- Mentors ask about goals, but mentees may not yet understand the landscape enough to answer meaningfully.
- There is no shared framework for how often to meet, what to cover, or what “success” looks like in the mentoring relationship.

Interpretation

- Mentorship is valued but currently underdirected and undersupported.
- Without structure, mentorship risks becoming comfort without progress—good intentions but limited impact.
- A more intentional design could turn mentorship into a true engine for leadership development and placement.

Implication

- IHLC should formalize a structured mentorship program (goals, tools, timelines) that connects mentoring conversations to concrete opportunities and leadership pathways.

Pillar 4: Leadership & Mentor Development

Theme 5: Committee Recruitment & Communication

What Surfaced

- Members often apply for committees and hear nothing back, sometimes multiple times.
- Staff generally forward applications promptly; the bottleneck is often in committee chairs' responses or decisions.
- There are no consistently communicated response-time expectations for chairs or co-chairs.
- Committees sometimes debate “fit,” but this can unintentionally feel like a closed door to motivated applicants.
- Members reported past experiences of being encouraged to apply but then never receiving confirmation or follow-up.

Interpretation

- Process gaps (rather than intentional exclusion) are producing experiences of exclusion.
- The lack of basic service standards (like timely replies) undermines trust and discourages emerging leaders.
- Committees risk becoming insular, not because they don't need people, but because processes are slow and opaque.

Implication

- IHLC should help set clear, enforceable communication and turnaround standards for committee recruitment and participation, ensuring that interested members receive timely responses and fair consideration.

Pillar 4: Leadership & Mentor Development

Theme 6: Accountability vs. “It’s Just Volunteer Work”

What Surfaced

- Participants acknowledged that ASMBS is a volunteer organization, but one with significant responsibilities (to the Board, members, and patients).
- Some leaders are extremely committed and supported by their home institutions; others struggle to balance responsibilities.
- There is frustration with “resume builders” who hold roles but do not actively participate.
- People see the need to hold feet to the fire, including their own, while still recognizing the realities of busy professional lives.

Interpretation

- The organization must navigate a tension between flexibility for volunteers and the need for reliability and performance.
- Without accountability, dedicated volunteers may feel overburdened and resentful, while passive leaders occupy key seats.
- Clear expectations and consequences are necessary to maintain credibility and operational effectiveness.

Implication

- IHLC should promote a culture where leadership roles come with clear expectations, accountability, and, when necessary, rotation out—protecting both the organization and highly engaged volunteers.

Pillar 4: Leadership & Mentor Development

Theme 7: Nurturing and Retaining Emerging Leaders

What Surfaced

- Two vulnerable groups were highlighted:
 - Members who ran for IHLC positions and were not elected.
 - Members who are interested in leadership but unsure how or where to start.
- There is concern that these individuals may drift away if not intentionally engaged.
- Ideas included:
 - Hosting calls with those who ran but were not elected to discuss other leadership options (committees, state chapters, task forces).
 - Using QR codes, social media, and meetups to connect “leadership-curious” members with current leaders.
 - Recognizing the emotional impact of not being elected and allowing time before re-engaging.

Interpretation

- The society already has a pool of motivated, high-potential members who have self-identified by running for roles or asking to get involved.
- Without structured follow-up, these members are at risk of feeling rejected and lost to the pipeline.
- Proactive outreach can turn a “no” in one area into a “yes” somewhere else, keeping talent engaged.

Implication

- IHLC should implement intentional follow-up and alternative pathways for emerging leaders—particularly those who have run for office—so that interest and energy are retained rather than lost.

Pillar 4: Leadership & Mentor Development

Theme 8: Leadership Pipeline & Succession as a System

What Surfaced

- There is recognition that pipeline management is currently informal and uneven.
- Leadership invitations sometimes come too early (e.g., being asked to run for Secretary after only six months in IHLC), creating stress and misalignment.
- Term limits are being introduced, but systems to identify, prepare, and move leaders through stages are not fully developed.
- People see the need to better connect:
 - Committee work
 - Speaking roles
 - State leadership
 - IHLC positions

Interpretation

- Leadership transitions have historically been personality-driven and opportunistic, rather than planned and transparent.
- There is a strong appetite for a coherent, mapped leadership pathway that makes it clear how members move from interest to involvement to leadership.
- A proper pipeline system would support equity, diversity, and continuity rather than relying on chance or informal networks.

Implication

- IHLC should help design and steward a formal leadership pipeline and succession plan, linking mentorship, committee recruitment, speaking opportunities, and elections into a coordinated system that continuously produces prepared, diverse leaders.

Pillar 4: Leadership & Mentor Development

Outliers & Notable Ideas

While most discussions centered on leadership expectations, mentorship gaps, and pipeline development, several standout ideas emerged that could transform how IHLC develops leaders across the organization.

Opening Leadership Doors Through Speaking Opportunities

- Speaking roles are a key gateway into leadership, yet barriers to adding new speakers limit emerging voices.
- Reserving dedicated speaking slots for new contributors could diversify and expand the leadership pool.

Follow-Up Outreach to Unsuccessful Candidates

- Personally contacting members who ran but were not elected would be a powerful retention and engagement strategy.
- This approach embeds emotional intelligence in leadership pipeline development.

Use of QR Codes and Social Media to Signal “Leadership Interest.”

- QR codes, meetups, and social-media prompts offer simple ways for members to express interest in leadership.

Structured Committee Chair Check-ins

- Quarterly meetings for committee chairs would reinforce expectations, alignment, and accountability.
- This shifts IH governance toward a more intentional and connected structure.

Staff-Led Templates and First-Draft Tools

- Leaders expressed interest in staff-created templates (policies, onboarding materials, guidelines).
- These tools would streamline work, offer consistency, and reduce workload—support that is now welcomed.

Transparency and Consistency in Committee Assignment

- Members often feel ignored when committee applications go unanswered.
- A two-step communication process (chair + staff partner) would improve responsiveness and trust.

Pillar 4: Leadership & Mentor Development

Strategic Programs of Work

To sustain a healthy leadership culture and ensure ASMBS has a steady pipeline of prepared, diverse leaders, IHLC must focus on intentional development, structured mentorship, process clarity, and transparent opportunities. These programs aim to build a leadership system in which new voices can enter, current leaders understand expectations, and succession is strategic rather than accidental.

1. Leadership Mindset & Term-Limit Culture
2. Role Clarity, Onboarding & Expectations
3. Structured Mentorship & Buddy Program
4. Speaker & Visibility Pipeline for Emerging Leaders
5. Committee Recruitment, Communication & Engagement Standards
6. Leadership Pipeline & Succession System

Pillar 4: Leadership & Mentor Development

Program 1: Leadership Mindset & Term-Limit Culture

Goal

Establish a sustainable leadership culture where terms are honored, transitions are intentional, and current leaders actively cultivate and prepare successors to ensure continuity, diversity, and long-term organizational health.

Key Elements

- Embed term-limit expectations for IHLC and all committees into governance documents and onboarding processes.
- Train leaders annually on stewardship, succession planning, and shared leadership practices.
- Require each leader to identify potential successors and create transition plans.
- Promote leadership turnover as a positive and necessary mechanism for pipeline growth and organizational resilience.

Primary Owners

- IHLC
- Governance/Bylaws Staff
- Executive Leadership

Pillar 4: Leadership & Mentor Development

Program 2: Role Clarity, Onboarding & Expectations

Goal

Ensure all leaders enter their roles with clear responsibilities, performance expectations, timelines, tools, and resources needed to contribute effectively and confidently.

Key Elements

- Develop standardized role descriptions and success indicators for IHLC members, committee chairs/co-chairs, and IHLC roles.
- Launch a comprehensive onboarding package with timelines, policies, templates, and decision pathways.
- Create a centralized Leadership Resource Hub with easy access to documents, tools, and communication guidelines.
- Implement structured orientation and periodic check-ins (mid-year and end-of-year) to reinforce expectations and identify support needs.

Primary Owners

- IHLC
- Governance
- Committee Operations Staff

Pillar 4: Leadership & Mentor Development

Program 3: Structured Mentorship Development System

Goal

Create a consistent, outcomes-driven mentorship program to support leadership growth by pairing emerging leaders with experienced mentors and linking mentorship activities to real leadership opportunities.

Key Elements

- Match mentors and mentees based on discipline, experience level, and leadership goals.
- Provide structured tools (goal-setting templates, meeting guides, development plans) to support productive mentoring relationships.
- Define minimum mentorship touchpoints and timelines to ensure progress and accountability.
- Track outcomes including committee placements, project leadership roles, and progression into speaker or IHLC opportunities.

Primary Owners

- IHLC
- Nominating/Leadership Development
- ASMBS Staff (support)

Pillar 4: Leadership & Mentor Development

Program 4: Visibility Pipeline for Emerging Leaders

Goal

Increase diversity and renewal in ASMBS leadership by building intentional mechanisms to elevate early-career and underrepresented members into speaking roles and high-visibility opportunities.

Key Elements

- Reserve a defined portion of speaking slots annually for new or first-time speakers.
- Develop a vetted database of IH speakers sourced from committees, mentorship programs, and state chapters.
- Establish clear, consistent criteria and workflows for selecting and approving new speakers.
- Monitor participation metrics to ensure balanced representation and prevent over-reliance on repeat speakers.

Primary Owners

- Program Committee
- IH Program Leadership
- Education Staff

Pillar 4: Leadership & Mentor Development

Program 5: Committee Recruitment & Engagement Standards

Goal

Create a transparent, responsive committee system that promptly acknowledges applications, clearly defines expectations, and supports and rewards active participation.

Key Elements

- Implement response-time standards for chairs (e.g., decision or acknowledgment within 3–5 business days).
- Utilize a two-step communication process (chair + staff partner) to prevent delays and ensure timely applicant follow-up.
- Establish baseline participation expectations (meeting attendance, email responsiveness, project contributions).
- Conduct annual participation reviews and rotate out inactive members to make space for highly engaged contributors.

Primary Owners

- IHLC
- Committee Chairs/Co-Chairs
- Governance/Committee Operations Staff

Pillar 4: Leadership & Mentor Development

Program 6: Leadership Pipeline & Succession

Goal

Develop a coordinated, transparent pipeline that identifies, develops, and advances emerging leaders into committee, IHLC, and state leadership roles.

Key Elements

- Create and publish a leadership pathway that illustrates how members can progress from initial involvement to advanced leadership.
- Maintain a centralized list of emerging leaders identified through committees, mentorship, speaking opportunities, and state chapters.
- Conduct intentional outreach to members who ran for leadership roles but were not elected, connecting them with alternative opportunities.
- Integrate mentorship, committee recruitment, and speaking roles into a single pipeline management system.
- Track progress and outcomes to evaluate gaps, strengths, and readiness across the leadership pool.

Primary Owners

- IHLC
- Nominating Committee
- State & Local Chapters Committee
- Executive Leadership

Pillar 4: Leadership & Mentor Development

What Success Could Look Like by 2028

By 2028, ASMBS IH leadership development and succession should be intentional, predictable, and thriving. Success may look like:

A Stable, Diverse Leadership Pipeline

- Each year, IHLC and committee leadership roles are filled with highly prepared candidates.
- Leadership slates reflect discipline diversity, early-career voices, and geographic spread.
- No role goes unfilled or filled out of urgency.

Clear, Accessible Leadership Expectations

- Every leader receives written expectations, onboarding, and a roadmap for success.
- Confidence replaces confusion; new leaders enter roles already knowing what to do.

Consistent Mentorship Leading to Real Opportunities

- At least 75% of mentees move into expanded roles (committee, project lead, speaker, state leadership).
- Mentorship is viewed as one of ASMBS's strongest member benefits.

Speaking Panels Featuring New Voices

- Each annual meeting includes 20–30% first-time speakers.
- Emerging leaders feel visible, valued, and supported.
- Member perception shifts away from “the same people always speak.”

Responsive, Transparent Committee Recruitment

- Applicants receive a response within five business days.
- Committee rosters are refreshed annually based on participation and interest.
- Members describe the process as fair, welcoming, and efficient.

Pillar 4: Leadership & Mentor Development

Stronger Integration With State Chapters

- IH leaders regularly flow between state and national leadership roles.
- State leaders receive structured support, mentorship, and onboarding.
- The national pipeline grows because of more active, supported state chapters.

A Sustainable Culture of Stewardship

- Leaders embrace term limits and succession as core responsibilities.
- The organization no longer depends on a small group of “usual leaders.”
- IHLC is known as a model leadership body within ASMBS.

Pillar 5: Innovation, Revenue, & Access

Purpose & Context

The Innovation, Revenue & Access pillar focuses on strengthening ASMBS's long-term sustainability by expanding non-dues revenue, modernizing educational delivery, and accelerating access to evidence-based obesity care. This conversation illuminated a shared understanding that innovation is not only about new ideas—it is about building systems that generate value for members, support comprehensive care nationwide, and amplify the Society's influence across clinical and policy landscapes.

As ASMBS approaches a major milestone with CBN accreditation, new opportunities are emerging to develop multi-disciplinary certifications, micro-credentials, and practical clinical tools that extend far beyond traditional CME. Participants emphasized the need to think creatively: reaching clinicians outside of bariatrics, developing ASMBS-branded resources, modernizing content delivery, and leveraging digital platforms to broaden impact and generate new revenue streams.

At the same time, meaningful gains in state-level access and underutilized advocacy funds signal that ASMBS has untapped capacity to influence reimbursement, utilization, and policy adoption. Aligning innovation with access—particularly through targeted educational resources, harm-reduction guidance around GLP-1 therapies, and simple toolkits for local advocacy—can significantly expand ASMBS's reach and effectiveness.

Together, these discussions framed Innovation, Revenue & Access as a forward-looking engine for growth, influence, and financial resilience—positioning ASMBS to deliver greater value to members and better outcomes for patients through 2028 and beyond.

Pillar 5: Innovation, Revenue, & Access

High-Level Summary

Key themes that emerged:

1. **CBN accreditation is a major strategic opportunity.** Members recognized that achieving CBN accreditation would unlock the ability to offer multiple accredited certificate programs and micro-credentials across all IH disciplines, as well as to clinicians outside bariatrics, creating both mission and revenue benefits.
2. **Members want ASMBS-branded tools and resources that are practical, current, and neutral.** There is high demand for updated flip charts, laminated guides, pocket references, and other point-of-care tools that reinforce evidence-based practice and generate sustainable non-dues revenue.
3. **A shift to digital-first, on-demand learning is essential.** Live webinar attendance is declining, while LMS engagement is strong. Participants emphasized the need to transition to pre-recorded sessions, integrate Q&A options, and centralize content distribution.
4. **ASMBS must lead on GLP-1/compounding education through a harm-reduction lens.** With rapid expansion of GLP-1 prescribing outside bariatrics, members see an urgent need for balanced, safety-oriented education for prescribers—and clear referral pathways to bariatric programs.
5. **Access and advocacy tools are underutilized and need clearer activation pathways.** Although grants and PAC resources are available, many members and institutions do not understand how to use them. Participants identified structured toolkits, templates, and state-level guidance as key opportunities.
6. **Innovation should be broad, creative, and mission-aligned—not limited to traditional education.** Members encouraged thinking beyond LMS modules, including media-training products, externally marketed courses, and new audiences such as PCPs, med-spa prescribers, and allied health providers.

Pillar 5: Innovation, Revenue, & Access

Thematic Analysis: Innovation, Revenue, & Access

Theme 1: Building a Scalable Certification & LMS Portfolio

What Surfaced

- CBN accreditation is close; once achieved, multiple certificates can sit under it (APPs, RDs, BH, surgeons, international, BE-SAFE).
- The group repeatedly framed this as a true certification, not just “more CME.”
- There is strong interest in using the LMS for certificate programs and micro-credentials, not just single webinars.
- Modules were discussed for non-bariatric clinicians who see obesity patients (PCPs, hospitalists, specialists), marketed beyond current membership.

Interpretation

- CBN accreditation is a cornerstone asset that can unlock a broad, tiered portfolio of certificates and courses.
- There is an appetite for expanding beyond current members to external audiences, positioning ASMBS as the “go-to” authority for obesity care education.
- Certification and structured learning pathways are seen as both mission-driven and revenue-generating.

Implication

- IHLC should actively shape a multi-disciplinary certification and micro-credential strategy that leverages CBN accreditation and LMS capacity to grow non-dues revenue and extend ASMBS’s educational reach.

Theme 2: Productizing Practical Tools & Resources

What Surfaced

- Participants described demand for pocket guides, laminated quick-reference sheets, flip charts, and similar tools for nurses, residents, and coordinators.
- Prior versions created by vendors (e.g., Medtronic flip charts) are outdated or downsized and not ASMBS-branded.
- Members see a clear advantage to neutral, ASMBS-branded tools versus vendor-branded materials when educating teams and health systems.
- These products are already selling in the marketplace (e.g., ED poster) and are seen as reasonably priced and valuable.

Interpretation

- There is strong, unmet demand for practical, point-of-care tools that simplify bariatric/emergency protocols and patient education.
- ASMBS-branded tools protect clinical neutrality and reinforce the Society's authority.
- These products are an easy, high-impact non-dues revenue stream with a clear member benefit.

Implication

- IHLC should prioritize developing a suite of practical, branded tools (guides, flip charts, pocket cards) as a core innovation and revenue line, tightly aligned with clinical standards and access goals.

Theme 3: Shifting from Live Webinars to Digital Content

What Surfaced

- Webinars are increasingly poorly attended live; attendance “is going down and down and down.”
- Conversely, LMS viewing numbers are strong, with members watching recordings repeatedly.
- There is a desire to move toward pre-recorded sessions, LMS hosting, and creative Q&A models (live Q&A “follow-ups,” LMS Q&A sections).
- High-quality content (e.g., SOARD Facebook live sessions) is often trapped on social media rather than integrated into the LMS.
- Fragmentation across channels (IH Facebook vs SOARD Facebook vs newsletters) means many IH members never see excellent content.

Interpretation

- Member behavior has shifted decisively toward on-demand consumption, and ASMBS needs to reflect that in its content strategy.
- There is a significant opportunity to repurpose and centralize high-value content currently siloed on social platforms.
- Better integration of content and channels will increase reach and monetization, while reducing “webinar fatigue.”

Implication

- IHLC should support a digital-first content strategy that prioritizes on-demand LMS offerings, systematic repurposing of existing content, and coordinated promotion across channels.

Theme 4: GLP-1 /Compounding Education

What Surfaced

- GLP-1 prescribing is expanding rapidly beyond bariatric programs to med spas, APPs, PCPs, pulmonologists, cardiologists, and others.
- Participants reported real-world cases in which they were asked, “What do I do with these patients?”
- There is concern about compounded GLP-1s, yet recognition that this practice is not going away.
- The group proposed harm-reduction-oriented education: not endorsing compounding, but providing best practices and referral pathways.
- Potential collaboration with other professional organizations (e.g., emergency medicine, primary care) was mentioned as a pathway to influence.

Interpretation

- GLP-1 therapies and compounding are a disruptive force and a strategic opportunity.
- If ASMBS does not provide balanced, safety-focused education, other, less qualified voices will fill the gap.
- Carefully framed, harm-reduction-oriented content could both protect patients and establish ASMBS as the trusted authority on the interface between surgery and pharmacotherapy.

Implication

- IHLC should help design a GLP-1/compounding education and referral program that balances risk, ethics, access, and innovation, positioning ASMBS as the leader in comprehensive, safe obesity care.

Theme 5: Underused Access & Advocacy Resources

What Surfaced

- Access to Care is seeing major wins in some states, with interest in expanding successes.
- Leadership cautioned against “doing all 50 states at once,” highlighting a need for prioritization and structure.
- Participants noted that grants and PAC funds exist but are underused; members and institutions often don’t understand what’s available or how to apply.
- Real examples were shared of people literally holding grant information and not knowing how to act on it.

Interpretation

- ASMBS has latent capacity in the form of grants, PAC resources, and advocacy infrastructure that is not fully activated.
- The gap is less about money and more about awareness, guidance, and simple tools for members to use with their hospitals, payers, and policymakers.
- Tightening these resources' ties to IH and state chapter leadership could accelerate coverage gains and utilization.

Implication

- IHLC should champion a structured Access & Advocacy Activation program that makes grants and PAC funds visible, navigable, and directly actionable for members at the local level.

Pillar 5: Innovation, Revenue, & Access

Outliers & Notable Ideas

These ideas were especially creative or underdeveloped but have high potential impact.

Media Training as a Revenue & Reputation Asset

- Use the existing media consultant (Roger Kissin) to create media-training modules for members and state chapters (how to talk to the press, language to use/avoid).
- This could live in the LMS as a paid resource, while simultaneously increasing ASMBS's media readiness and public messaging consistency.

ASMBS-Branded Pocket Guides & Flip Charts

- Replace vendor-branded, outdated pocket cards/flip charts with ASMBS versions, tailored to coordinators, nurses, residents, and emergency teams.
- These can be sold in the marketplace and deployed as standard tools across programs – small-ticket, high-impact.

Cross-Leveraging the SOARD Facebook Community

- SOARD's Facebook page has ~2,000 followers, many of whom are not active in IH channels or are not necessarily ASMBS members.
- Idea: use that community as a targeted funnel for:
 - Inviting people to join ASMBS or IH.
 - Driving traffic to LMS content and key campaigns.
 - Promoting selected high-value sessions (e.g., GLP-1, comprehensive care).

External Education for GLP-1 Prescribers

- Offer non-judgmental, harm-reduction-oriented education to med spas, APPs, and other prescribers.
- Frame as “supporting safe, evidence-based care” and encouraging referrals back to bariatric programs when indicated.

Pillar 5: Innovation, Revenue, & Access

Recommended Strategic Programs of Work

The Strategic Programs of Work for this pillar focus on transforming innovation into a sustainable engine for mission impact, educational reach, and financial strength. Building on the group's insights, these programs center on leveraging CBN accreditation to expand certification pathways, developing ASMBS-branded clinical tools, modernizing digital learning, leading harm-reduction education around GLP-1 therapies, and activating underused access and advocacy resources. Together, these initiatives create a coordinated roadmap that blends creativity with operational discipline—positioning ASMBS to grow its influence, diversify revenue, and support comprehensive obesity care in ways that are scalable, relevant, and future-focused.

1. CBN-Anchored Certification & Micro-Credentials
2. ASMBS-Branded Clinical Tools & Resource Line
3. Digital-First Content & Channel Integration Strategy
4. GLP-1 & Compounding Education Initiative
5. Access & Advocacy Activation and Grant Utilization

Pillar 5: Innovation, Revenue, & Access

Program 1: CBN-Anchored Certification & Micro-Credentials

Goal

Leverage CBN accreditation to build a scalable portfolio of multi-disciplinary certificate and micro-credential programs that generate non-dues revenue and position ASMBS as the leading education provider in comprehensive obesity care.

Key Elements

- Finalize and maintain CBN accreditation as the umbrella for additional certificate programs.
- Design modular, stackable certificates for APPs, dietitians, behavioral health, surgeons, international IH, and BE-SAFE participants.
- Develop targeted courses for non-bariatric clinicians (PCPs, hospitalists, specialists) who manage patients with obesity.
- Integrate all certificates into the LMS with clear pricing, pathways, and marketing campaigns inside and outside ASMBS.
- Establish outcome measures (enrollment, completion, revenue, learner satisfaction) and review annually.

Primary Owners

- Certification/CBN Leadership
- Education Staff
- IHLC
- Program Committee

Pillar 5: Innovation, Revenue, & Access

Program 2: ASMBS-Branded Clinical Tools & Resource Line

Goal

Create a standardized suite of ASMBS-branded clinical tools (pocket guides, flip charts, laminated cards, quick-reference sheets) that support high-quality care, reinforce ASMBS's authority, and generate sustainable non-dues revenue.

Key Elements

- Inventory existing tools (e.g., old vendor flip charts) and identify priority updates aligned with current guidelines.
- Develop discipline-specific versions (coordinators, nurses, residents, ED teams, med-surg staff).
- Produce print and digital formats, sold via the ASMBS marketplace and used at meetings and state chapter events.
- Coordinate with vendors to avoid conflicts, while reinforcing ASMBS's role as the neutral, evidence-based standard.
- Monitor usage and sales data to inform new editions and future tools.

Primary Owners

- Clinical Issues Committee
- IHLC

Program 3: Digital-First Content & Channel Integration Strategy

Goal

Shift from low-attendance live webinars to a digital-first, on-demand content strategy that maximizes reach, monetization, and learner engagement across LMS and social channels.

Key Elements

- Set a default model of pre-recorded sessions with scheduled launches and optional live Q&A segments.
- Establish workflows to capture, edit, and upload high-value content from Facebook Lives, meetings, and special sessions into the LMS.
- Harmonize messaging across IH Facebook, SOARD Facebook, newsletters, and the LMS with coordinated promotion calendars.
- Track user analytics (views, completions, time spent) to prioritize high-impact topics for further development.
- Create a simple “content intake” process that allows committees and leaders to propose and quickly produce new digital offerings.

Primary Owners

- Education/Communications/Marketing Staff
- IHLC
- SOARD/Editorial Leadership

Pillar 5: Innovation, Revenue, & Access

Program 4: GLP-1 & Compounding Education Initiative

Goal

Provide balanced, harm-reduction-oriented education on GLP-1 therapies and compounding to internal and external clinicians, promoting safe practice and timely referral to comprehensive bariatric care.

Key Elements

- Develop a GLP-1/compounding education series in the LMS, framed around safety, best practices, and indications for surgery referral.
- Tailor versions for bariatric teams, med-spa prescribers, PCPs, and specialists (cardiology, pulmonology, sleep, etc.).
- Collaborate with relevant professional societies (where appropriate) for cross-promotion without endorsing specific products or compounding entities.
- Craft careful messaging emphasizing harm reduction, patient safety, and evidence-based care, clearly stating that ASMBS does not endorse specific compounded agents.
- Integrate referral tools (find-a-provider links, ASMBS membership prompts, state chapter contacts) to capture downstream clinical and membership value.

Primary Owners

- Clinical Issues Committee
- Access to Care Committee
- Public Education Committee
- IHLC
- Education Staff

Program 5: Access & Advocacy Activation and Grant Utilization

Goal

Increase the impact of ASMBS advocacy by making access-related grants, PAC resources, and state support more visible, understandable, and actionable for members and their institutions.

Key Elements

- Create a clear Access Resource Guide outlining available grants, PAC funds, eligibility, and application processes.
- Develop toolkits with templates (ask letters, proposals, slide decks, talking points) that members can use with hospitals, payers, and policymakers.
- Prioritize states based on readiness and opportunity, aligning IH leaders, state chapters, and access-to-care efforts.
- Highlight success stories to model what is possible and inspire replication.
- Track grant utilization, outcomes (policy changes, coverage expansions), and share impact reports with IHLC and the Board.

Primary Owners

- Access to Care Committee
- TREC Foundation & PAC
- State & Local Chapters Committee
- IHLC
- Executive Leadership

Pillar 5: Innovation, Revenue, & Access

What Success Could Look Like By 2028

By 2028, innovation, revenue, and access work would have transformed from scattered efforts into a coherent, high-impact engine for ASMBS.

Robust Non-Dues Revenue & Certification Portfolio

- Multiple accredited certificate programs (4–6) are currently live under the CBN umbrella.
- Non-dues revenue from LMS and products has significantly increased, supporting strategic priorities without over-reliance on dues.

High-Use ASMBS-Branded Tools

- Pocket guides, flip charts, and laminated resources are widely used across programs and state chapters.
- Members and hospitals identify ASMBS materials as the standard reference, not vendor pieces.

Digital-First Learning with Strong Engagement

- Most educational offerings in the LMS are on-demand, with optional live components where needed.
- Key metrics (views, completions, CE claims) are trending upward year over year, reflecting members' preferences and value.

Recognized Authority on GLP-1 & Comprehensive Care

- Internal and external clinicians recognize ASMBS as a trusted source on GLP-1 use, compounding risks, and when to refer for surgery.
- Harm-reduction, safety-focused modules are widely accessed and referenced in clinical practice.

Fully Activated Advocacy & Access Resources

- Advocacy grants and PAC funds are regularly and strategically used by members and state chapters.
- Members understand how to access support and feel equipped to advocate locally.

Additional Discussions & Wrap-Up Considerations

In the closing portion of the meeting, several threads emerged that cut across all five pillars and pointed toward how the IHLC can sustain momentum after this face-to-face session.

- **Obesity Summit Workstreams as a Unifying Platform**
 - The six Obesity Summit workstreams include multiple societies and stakeholders.
 - IHLC members were encouraged to actively join or re-engage with these workstreams, as they offer a powerful vehicle to:
 - Align IH priorities with national multi-stakeholder efforts.
 - Ensure comprehensive care and IH perspectives are embedded in tools, standards, and messaging.
 - Amplify IHLC's influence beyond ASMBS through joint products and shared resources.
- **Committee Execution, Timeliness, and Project Follow-Through**
 - The round-robin committee updates surfaced a recurring pattern: great ideas and approved concepts sometimes stall at the proposal or execution phase (e.g., GLP-1 LMS module, behavior health guidance, webinar series).
 - Key issues highlighted:
 - Bottlenecks occur when project leads are overextended or unclear about next steps.
 - Delay in submitting project proposals and in responding to committee applications.
 - Time-sensitive topics (GLP-1s, medications, updated guidance) are losing momentum if not moved quickly.
 - This reinforces the Leadership & Mentor Development pillar themes: IHLC needs clearer expectations, timelines, and accountability structures for committee work.

- **Major Content & Credentialing Projects Are Underway and Need Support**
 - Several flagship efforts are in motion and will shape IH identity for years:
 - CBN accreditation and exam evolution.
 - Updated micronutrient guidelines and contraception paper through Clinical Issues.
 - New advanced bariatric nutrition work and the Registered Dietitian Committee build-out.
 - Behavior health pre-surgical evaluation guideline update.
 - These projects will require sustained authorship, rigorous methods, and attention to publication standards—again underscoring the need for robust leadership pipelines, mentoring, and clear expectations.

- **Communication, Visibility, and Member Awareness Remain Systemic Gaps**
 - From missing webinar recordings on the LMS to low awareness of SOARD Facebook content, many valuable products are not reaching their intended audiences.
 - Members called out:
 - The need for consistent cross-promotion (IH Facebook, SOARD page, newsletters, LMS).
 - Better use of simple tools (invites, short videos, QR codes, structured updates) to draw members into content and committees.
 - This aligns with earlier themes in Membership, Education, and Leadership: ASMBS is producing meaningful resources, but discoverability and communication infrastructure lag behind.

Taken together, these closing discussions reinforce the central message of the retreat: IHLC is rich in ideas, commitment, and emerging infrastructure, but future success depends on execution discipline, communication, and intentional linkage across initiatives. By connecting Obesity Summit workstreams to IHLC priorities, tightening committee processes and mentorship, supporting large guideline and credentialing projects, and improving how we surface and share our work, the IHLC can turn this strategic framework into visible, measurable progress by 2028.