



White Paper

***Obesity
Management
Quality Improvement
Collaborative***



Obesity Management Quality Improvement Collaborative

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Executive Summary

Obesity affects roughly 4 in 10 U.S. adults and is a driver of diabetes, cardiovascular disease, and other chronic conditions, yet it remains underdiagnosed and undertreated in routine primary care. In 2024, AMGA Foundation launched the Obesity Management Quality Improvement Collaborative, a multiyear initiative supported by an independent grant from Lilly, to increase the number of people with obesity who receive a formal diagnosis, evidence-based comprehensive care—including counseling, nutrition, and medical and surgical therapeutic interventions—and education on the importance of long-term sustainable outcomes.

Six healthcare organizations participated: Advocate Health–Midwest, HealthPartners, Novant Health, Ochsner Health, SIMEDHealth, and UC San Diego Health. Together they represent an active patient population of approximately 3.6 million adults. Over an intervention period running from September 2025 through May 2026, participating organizations built and tested electronic health record (EHR) tools, launched virtual weight-management clinics, expanded GLP-1 medication support, and developed multidisciplinary referral pathways connecting primary care, endocrinology, behavioral health, nutrition, and bariatric services.

Across the Collaborative, the group-weighted average rate of formal obesity diagnosis (Measure 1) rose from 57% at baseline to 63% in the final reporting period, and the group-weighted average rate of any guideline-recommended obesity treatment (Measure 2) rose from 23% to 33%. SIMEDHealth and Novant Health met the Collaborative’s 10% care-gap-closure goal for diagnosis; UC San Diego Health, Novant Health, and SIMEDHealth met the 5% care-gap-closure goal for treatment. Every organization improved at least one measure, and several developed reusable infrastructures—including EHR order sets, referral pathways, and reporting dashboards—that are expected to outlast the formal Collaborative period.

Background

Obesity is a chronic, relapsing disease associated with increased risk of type 2 diabetes, cardiovascular disease, and many cancers.^{1,2} Prevalence varies substantially by geography and population; in North Carolina, for example, 69.2% of adults were overweight or obese in 2024.³ Research has shown that patients are more likely to achieve meaningful weight loss when their obesity is formally diagnosed rather than addressed only informally during a visit for another condition.⁴

Despite this, obesity is frequently absent from the documented problem list, and evidence-based treatment—including lifestyle and behavioral counseling, nutrition services, obesity medications, and metabolic or bariatric procedures—is inconsistently offered even when a diagnosis is present. The rapid rise in demand for GLP-1 medications has intensified this gap: Primary care teams report a surge in patient requests for these medications, often without a formal diagnosis, standardized follow-up, or documentation of side effects and progress.

Scale: ~3.6 million active patients across 6 healthcare organizations

Duration: Baseline Sept. 2024 – Aug. 2025; Intervention Sept. 2025 – May 2026

Measure 1 (Diagnosis):
57% → 63% group-weighted average (goal: 10% care-gap closure)

Measure 2 (Any Weight Management Treatment):
23% → 33% group-weighted average (goal: 5% care-gap closure)

Collaborative Approach and Goal

AMGA Foundation used its established Best Practices Learning Collaborative framework, the same model applied in the prior Obesity Care Model Collaborative (OCMC), to structure the Obesity Management Quality Improvement Collaborative. The Collaborative's goal was:

To increase the number of people with obesity who receive a formal diagnosis; evidence-based, comprehensive care, including counseling, nutrition, and medical and surgical therapeutic interventions; and education on the importance of long-term, sustainable outcomes.

Objectives

- Improve screening and documentation of obesity diagnosis in adults in primary care settings.
- Improve evidence-based obesity care among adults receiving obesity management treatment, including personalized patient-centered care, lifestyle changes, behavioral counseling, nutritional services, obesity medications, and metabolic or bariatric interventions.
- Identify patient populations with lower rates of diagnosis and evidence-based care and develop health equity strategies to address barriers.
- Improve coordination of services among primary care physicians and specialists within each health system or medical group.

Advisory Support

The Collaborative drew on subject-matter guidance from a national advisory committee that included representatives from a participating health system, a partner physician organization, and the Obesity Action Coalition (OAC), which served as an official Collaborative patient-advocacy partner. The American Association of Clinical Endocrinology (AACE) also served as an official Collaborative partner.

- Natasha Malesevich, MHA, Primary Care Service Line Admin Manager, Weight Management, Advocate Health–Midwest
- Kara Mayes, MD, FAAF, Chief Medical Officer, Ilant Health
- Joe Nadglowski, President/CEO, Obesity Action Coalition

Participating Organizations

Six multispecialty medical groups and integrated health systems, spanning academic, physician-owned, and large integrated delivery settings across the Midwest, South, Southeast, and West, participated in the Collaborative:

- Advocate Health–Midwest: Chicago-area integrated system
- HealthPartners: Minnesota and western Wisconsin
- Novant Health: North Carolina, South Carolina, and Georgia/Florida markets
- Ochsner Health: Louisiana and the Gulf South
- SIMEDHealth: North Central Florida, independent physician-owned group
- UC San Diego Health: the region's only academic health system

Advocate Health and Novant Health contributed the largest active patient populations in the Collaborative, each with approximately 1.2 million active patients; across all six organizations, the Collaborative's combined active patient population totaled approximately 3.6 million adults.

Methodology and Timeline

Each organization submitted data on a rolling quarterly basis for two Collaborative measures, tracked from four quarters of a baseline period through three quarters of an intervention periods. The active patient population for each reporting period was defined as adults ages 18–79 with at least one qualifying primary care, endocrinology, or specialty-with-assigned-primary care physician (PCP) visit in the prior nine months, excluding patients with hospice, palliative care, pregnancy, or death recorded in that window.

Period	Reporting Window	Submission Due
Baseline 1–3	Sept. 2024 – May 2025	Aug. 2, 2025
Baseline 4	June – Aug. 2025	Sept. 17, 2025
Interim (Int. 1–2)	Sept. 2025 – Feb. 2026	Mar. 17, 2026
Final (Int. 3)	Mar. 2026 – May 2026	June 17, 2026

Site Interventions and Innovations

Each organization tailored its interventions to local infrastructure, population, and workflow. Representative examples are summarized below, organized by the four AMGA Obesity Care Model (OCMC) domains where applicable: Community; Healthcare Organization; Care Team; and Patient & Family.

Advocate Health–Midwest

Advocate built on its established Medical Weight Management program, which spans surgical (endoscopic, restrictive, malabsorptive, revisional), medical (obesity specialists, endocrinologists, primary care, medications), and lifestyle/behavioral services (dietitians, meal replacement, health coaching, behavioral health, sleep medicine, physical therapy). During the Collaborative, Advocate focused on expanding access: It launched a Virtual Enterprise Weight Management Program, added provider capacity, and introduced asynchronous, MyChart-based chronic e-visits for GLP-1 follow-up in primary care.

- The Virtual Enterprise Weight Management Program in Wisconsin and Illinois generated 919 internal referrals (72% from primary care) and 1,311 completed visits, with 92% average utilization. Average lead time for new appointments fell from 90 to 15 days in Wisconsin and from 64 to 36 days in Illinois.
- 1,466 weight management (GLP-1) chronic e-visits were initiated, and expansion to weight management specialty is planned. New full-time equivalents (FTEs), expanded hours, and standardized visit types helped grow quarterly weight management visits from 5,636 to 14,166. Virtual group visits also launched, with an expansion playbook in development.
- The Obesity Summit drew 407 registered attendees (90 in-person, 239 virtual) and featured 12 experts, 14 exhibitors, and 4 CME credits. A MEDTalk on Anti-Obesity Medications drew 163 attendees. Bariatric surgery bias/stigma training is being expanded to all weight-management staff.
- Advocate completed its social drivers of health (SDOH) screener rollout for primary care Medical Weight Management specialists, with referrals through FindHelp to community food-security and physical-activity resources.
- **Final results:** Measure 1 (Diagnosis) 61.8% (baseline 4) → 61.3% (final); Measure 2d (Any Treatment) 20.5% (baseline 4) → 24.4% (final).

HealthPartners

HealthPartners entered the Collaborative with established obesity services. These include a Bariatric Surgery and Weight Loss Center of Excellence, a Medicare Intensive Behavioral Therapy program (nine locations), and the Melrose Center for Eating Disorders. They also include a Primary Care Valley Weight Management Clinic in western Wisconsin that combines MD visits, nutrition services, and downstream health coaching and body-composition scanning. During the Collaborative, HealthPartners built on this foundation through clinician education, improved diagnosis documentation, and new Epic tools to strengthen how primary care identifies and treats obesity.

- HealthPartners ran a Maintenance of Certification (MoC) project from March to May 2026 with 56 clinicians, which included clinician bias training. The MoC cohort reached a 67.3% diagnosis rate in May. Working with its diagnosis accuracy team, HealthPartners also launched new training on obesity diagnosis, coding, and documentation on March 1, 2026.
- Three half-day work sessions produced a multidisciplinary treatment algorithm, modeled on Advocate Health's, spanning bariatric services, nutrition, physical therapy, and other resources. A new Epic workgroup embedded the algorithm and continues to refine the SmartSet. The team also built Epic tools and training for GLP-1 prescribing, including oral medications, and created a new patient education packet.
- Organization-wide engagement in lifestyle, nutrition, and behavioral counseling stayed flat (8.0% → 7.8%) but rose among MoC clinicians (10.2% → 10.9%). An expert panel has begun building an internal weight management champion clinician program.
- **Final results:** Measure 1 53.4% (baseline 4) → 55.2% (final); Measure 2d 25.2% (baseline 4) → 28.4% (final).

Novant Health

Novant Health, the Collaborative's largest participating population, focused on increasing engagement with weight management services among patients with BMI >35. It launched a Virtual Weight Management Clinic offering nutritional counseling, exercise planning, behavioral support, and medication management, with pharmacist practitioner involvement when appropriate.

- Novant implemented proactive outreach using a weekly electronic medical record (EMR) report to identify patients with BMI >35. Outreach combined automated MyChart messages, follow-up calls to nonresponders, and brief provider scripts introducing weight management programs during visits.
- Novant partnered with its marketing team to distribute culturally tailored obesity education (English and Spanish) via social media. Direct engagement metrics stayed flat, but providers reported more patients raising weight-management questions during visits.
- **Final results:** Measure 1 41.8% (baseline 4) → 48.7% (final); Measure 2d 22.8% (baseline 4) → 31.1% (final). Novant Health met both Collaborative care-gap-closure goals.

Ochsner Health

Ochsner focused on embedding real-time clinical decision support directly into the primary care workflow and on increasing obesity diagnoses on the Epic problem list. Ochsner also continued a GLP-1 offering within its self-insured employee health plan, now completing its second program year.

- Ochsner developed and implemented an Epic Obesity Management SmartSet, refined through 50+ rapid-cycle PDSA tests with input from multiple stakeholders and continuous end-user feedback. The SmartSet has been live since December 1, 2025, and in its first four months generated 574 lab orders, 550 medication orders, 63 referrals, 14 e-consults, and 78 sleep studies.
- **Final results:** Measure 1 60.3% (baseline 4) → 62.5% (final); Measure 2d 30.4% (baseline 4) → 32.0% (final).

SIMEDHealth

SIMEDHealth, an independent, physician-owned multispecialty group, adopted an integrated, primary-care-led model for obesity care that combined EHR workflow tools, transparent physician-level reporting, and reinforced messaging across the organization.

- SIMEDHealth built an obesity management pathway in its EHR. After a pilot, the pathway was relaunched with usability revisions and later updated for Centers for Medicare and Medicaid (CMS) GLP-1 Bridge Program guidelines. SIMEDHealth also added obesity registry data to its suspect-condition workflow to flag patients for diagnosis, and its EHR team implemented an automated prior-authorization support tool for obesity treatments.
- Physician/National Provider Identifier (NPI)-level performance reports were distributed at baseline and midpoint, with final reports to follow. Obesity data were presented at three practice meetings, and a physician-developed lifestyle handout was added to the EHR for clinics to print.
- Health Equity Project: Education materials and physician-level reports addressed a seven-point gender gap in obesity diagnosis, showing each provider's gap between men and women. By the end of the Collaborative, the gap had narrowed by nearly three points.
- SIMEDHealth launched "Mission SlimPOSSIBLE!," an employee weight-loss challenge with three monthly mini-challenges. About 15% of employees participated, and participants achieved 3.81% cumulative weight loss.
- **Final results:** Measure 1 64.8% (baseline 4) → 87.3% (final), the highest diagnosis rate in the Collaborative and the largest improvement of any organization; Measure 2d 18.2% (baseline 4) → 24.7% (final). SIMEDHealth met both Collaborative care-gap-closure goals.

UC San Diego Health

UC San Diego (UCSD) Health's Center for Advanced Weight Management connects primary care, endocrinology, general internal medicine, pediatrics, hospital medicine, and population health around a single referral pathway. UCSD's signature intervention used Population Health bulk referrals and MyChart messages to invite eligible patients into the UCSD COACH program. COACH is an online platform offering personalized 1:1 health coaching, physical activity and nutrition education, and a resource library.

- UCSD placed 2,300 bulk referrals in its first PDSA cycle (September–November 2025) and 5,980 more between November 21, 2025 and March 1, 2026. The COACH pilot, initially capped at 100 participants, had 150 enrolled and 87 actively engaged by March 2026. It then expanded with an additional health coach. Enrollment required considerable manual staff follow-up.
- The Physician Champion led education on GLP-1s, weight bias, and health equity at department, general internal medicine, and faculty meetings. UCSD also extended an underused weight management SmartSet from faculty practices to Community Care practices.
- Outreach focused on Medi-Cal patients. Staff scheduled those due for visits and added appointment-deck notes reminding PCPs to address weight management. A PharmD developed a quick-reference guide to GLP-1 coverage across health plans to support prior authorizations and the refill clinic.
- **Final results:** Measure 1 57.8% (baseline 4) → 60.5% (final); Measure 2d 21.6% (baseline 4) → 55.9% (final), the largest treatment-rate improvement of any Collaborative organization, meeting the treatment care-gap-closure goal.

Collaborative Measures

The Collaborative tracked two primary measures, each stratified by age, sex, race, ethnicity, insurance type, and obesity class, using shared measure denominator and numerator definitions across all six organizations.

Measure 1: Obesity Diagnosis

Percent of active adults with BMI ≥ 30 who have a documented diagnosis of obesity, active on the patient problem list or present on a claim. This measure matters because patients with a formal obesity diagnosis have been shown to achieve greater weight loss than those without one.⁵

Measure 2: Obesity Care

Percent of active adults with BMI ≥ 30 who received guideline-recommended obesity management treatment, broken into four sub-measures:

- 2a: Lifestyle changes, behavioral counseling, or nutritional services
- 2b: Obesity medications
- 2c: Metabolic or bariatric surgery, or endoscopic procedures
- 2d: Any one or more of the above (“Any Treatment”)

Collaborative-wide goals were a 10% relative care-gap closure for Measure 1 (equivalent to a 4–5 percentage-point absolute increase from the final baseline period) and a 5% relative care-gap closure for Measure 2 (a 3–4 percentage-point absolute increase).

Results

Population Reached

The active patient population across the six organizations showed the following characteristics, consistent across most sites: Patients ages 45–64 made up a similar share of the population at every organization (34% to 38%), while the 18–44 and 65–79 age bands varied more widely (22% to 42%). Most organizations served a higher proportion of female patients (48% to 60%). Racial and ethnic composition varied by region: White patients ranged from 59% to 75% of the active population, Black patients from 3% to 28%, Asian patients from 2% to 16%, and Hispanic patients from 4% to 17%. Commercial insurance (including Medicare Advantage) covered 76–80% of active patients, Medicare 7% to 19%, and Medicaid 1% to 11%.

Obesity prevalence (BMI ≥ 30) among active patients ranged from 21% to 45% across organizations, consistent with regional and state-level obesity prevalence data, and was notably uneven across demographic groups: Prevalence was highest among Black patients (39% to 63%) compared with White (20% to 44%) and Asian (13% to 20%) patients, and highest among Medicaid patients (30% to 56%) compared with commercially insured patients (21% to 46%).

Measure 1: Obesity Diagnosis — Results

	Baseline	Final (Int 3)	Absolute Change
Group-weighted average	57%	63%	+6 pts

Across the Collaborative, diagnosis rates were highest among patients with Obesity Class III (BMI ≥ 40), reaching 65% to 100% depending on organization, compared to Obesity Class I ($30 \leq \text{BMI} < 35$; 39% to 79%). At most organizations, patients ages 65+, female patients, and Black patients had higher diagnosis rates than younger patients, male patients, and other racial groups, respectively, though the gains driving overall improvement varied by site. SIMEDHealth’s largest gains came from previously underdiagnosed male patients and older adults (ages 65–79, +20%), and they narrowed a 7-point gender gap in diagnosis by nearly 3 points during the Collaborative. UC San Diego Health and Novant Health saw their largest gains

among Hispanic patients when compared to non-Hispanic patients, reducing that disparity gap by 1–2 percentage points. UC San Diego Health, Novant Health, and Ochsner Health also saw their large gains among their Medicaid patients. SIMEDHealth and Novant Health each met the Collaborative’s 10% care-gap-closure goal for diagnosis.

Measure 2: Obesity Care — Results

	Baseline	Final (Int 3)	Absolute Change
Any Treatment (2d), group-weighted average	23%	33%	+10 pts

Across the Collaborative, 22–30% of eligible patients were receiving obesity medications by the final period (improvements of 0–9 percentage points from baseline), while only 1% to 3% were receiving metabolic or bariatric surgery or endoscopic procedures. Lifestyle, behavioral, or nutritional interventions ranged from 2% to 46%. “Any treatment” rates tracked closely with medication rates, indicating that few patients received other treatment types without also being prescribed an obesity medication, a signal that lifestyle and behavioral pathways remain the Collaborative’s biggest opportunity for further improvement. UC San Diego Health had the Collaborative’s largest single-organization treatment gain, driven by its bulk-referral and COACH coaching workflow. UC San Diego Health, Novant Health, and SIMEDHealth each met the Collaborative’s 5% care-gap-closure goal for treatment.

Cross-Collaborative Patterns and Lessons Learned

EHR Infrastructure Is Never “Done” in One Cycle

Every organization rebuilt some piece of its EHR workflow, SmartSets, problem-list prompts, referral order sets, or bulk-ordering tools, and every organization iterated on that build at least once. Ochsner’s and HealthPartners’ SmartSets alone each went through more than 50 rapid PDSA cycles before reaching production. Organizations planning similar work should expect to treat EHR tools as living infrastructure, not a one-time build.

Medications Are Currently Driving Treatment Gains

Between 22% and 33% of eligible patients were receiving obesity medications by the end of the Collaborative, and “any treatment” rates moved almost in lockstep with medication rates. This reflects the current reality of GLP-1 demand in primary care, but it also means lifestyle, behavioral, and nutritional pathways remain the most underused levers and the most promising targets for the next phase of work.

Multidisciplinary Care Models Are Taking Shape, Differently at Each Site

Bariatric services, dietitians, pharmacy, care management, and primary care were woven together differently at every organization. SIMEDHealth’s model stayed primary-care-led with community referral; UC San Diego Health centralized coordination through population health and a bulk-referral pathway; HealthPartners built a dedicated multidisciplinary treatment algorithm. The specific model varied, but the direction toward more structured coordination between primary care and specialty obesity services was consistent.

Disparities Persist and Must Be Actively Tracked

Obesity prevalence was consistently highest among Black patients (37% to 63% across organizations) and Medicaid-insured patients (30% to 56%), populations that also, at several sites, started the Collaborative with lower diagnosis and treatment rates. Tracking these gaps by demographic group—as SIMEDHealth did through transparent, stratified reporting and its dedicated Health Equity Project on the gender diagnosis gap, and as UC San Diego Health did through its deliberate Medicaid patient outreach—was consistently the first step toward closing them.

Transparent, Physician-Level Data Drive Behavior Change

SIMEDHealth's approach illustrates a pattern echoed across the Collaborative: Pairing pre-visit patient identification with physician-level (not just organization-level) reporting created intrinsic motivation for individual clinicians, while reinforcing the initiative across multiple communication channels, including six practice-meeting presentations over the Collaborative period, helped it “stick.” HealthPartners emphasized that data is only useful if organizations have a plan to keep collecting it after a formal Collaborative period ends.

Challenges and Opportunities for Continued Work

- Younger adults (ages 18–44) remained the hardest population to reach for diagnosis at most organizations, with diagnosis rates as low as 43%, even as older age groups approached 90%.
- Lifestyle, behavioral, and nutritional treatment lagged behind medication-driven treatment at every organization, suggesting a continued need for scalable, low-friction behavioral and nutrition pathways that do not depend on a medication prescription.
- Metabolic and bariatric surgery or endoscopic procedures remained rare (1% to 3% of eligible patients) relative to medical management, reflecting well-documented access and referral barriers to surgical obesity treatment.
- Not every intervention could be tied to a quantified outcome within the reporting period; several sites' community and patient-engagement initiatives (SDOH screening, website redesigns, social media outreach) were tracked qualitatively or through process measures, rather than diagnosis or treatment rates, and will need continued measurement to demonstrate impact.
- Sustaining momentum after the formal Collaborative period will depend on organizations' ability to continue pulling and reviewing their own data, as several sites' Maintenance of Certification and quality-reporting infrastructure were built specifically to outlast the grant period.

Collaborative Deliverables

The Obesity Management Quality Improvement Collaborative produced a set of deliverables intended to document results and extend the Collaborative's impact beyond the six participating organizations:

- Obesity Care Model Collaborative Playbook Addendum: New plays, extending AMGA's existing Obesity Care Model Playbook with successful interventions from each organization, tagged by intervention category (Services; Roles & Education; Tools & Workflow; Measurement & Evaluation; Reimbursement; Advanced) and organized by OCMC domain.
- Best-practices infographic mapping each organization's successful interventions to the four OCMC domains—Community, Healthcare Organization, Care Team, and Patient & Family—alongside each organization's Measure 1 or Measure 2d outcome; this infographic is the source for the current-cycle interventions being incorporated into the OCMC Playbook.

Conclusion and Next Steps

Over a nine-month implementation period, the six organizations in the Obesity Management Quality Improvement Collaborative moved the group-weighted average obesity diagnosis rate from 57% to 63% and the group-weighted average rate of any guideline-recommended obesity treatment from 23% to 33%, while building EHR tools, referral pathways, and virtual care models that most organizations intend to sustain beyond the Collaborative's formal end. Four of six organizations met the Collaborative's treatment care-gap-closure goal, and two met the diagnosis care-gap-closure goal, with every organization improving at least one measure.

Final data were submitted to AMGA on June 17, 2026, and participating organizations submitted final quality improvement action plans on June 19, 2026. AMGA Foundation and Lilly have since extended the Collaborative into a follow-on phase running through June 2027, during which four of the original six participating organizations will continue to refine their interventions. During the extension period, participating health systems will implement targeted interventions to close remaining gaps in obesity diagnosis and treatment. To improve diagnosis, organizations will lower outreach eligibility thresholds to BMI ≥ 30 , give providers monthly reports on patients with undiagnosed obesity, and strengthen EHR decision support. To expand treatment, they will grow virtual weight management capacity, launch specialty e-visits, and use Medicare GLP-1 Bridge Program tools to increase GLP-1 access. A clinician education video will also address diagnosis and treatment for priority populations, including younger adults, men, Asian and Hispanic patients, and Medicaid enrollees.

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Mission

AMGA Foundation enables medical groups and other organized systems of care to consistently improve health and healthcare.

Vision

AMGA Foundation serves as a catalyst, connector, and collaborator for translating the evidence of what works best in improving health and healthcare in everyday practice.



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