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Original Research

Integrating Education and Practice Change to Improve Obesity Management: A Multisite Quality Improvement Initiative **AQ1**

Improving Obesity Care Through Multisite QI

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Footnotes

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OBJECTIVE

Despite evidence-based guidelines and expanding pharmacologic treatment options, obesity remains underdiagnosed and undertreated, reflecting limited clinician confidence, workflow constraints, and gaps in patient engagement. This study evaluated a multisite quality improvement (QI) initiative integrating continuing medical education (CME) and practice-level interventions in obesity diagnosis, multimodal care planning, and antiobesity medication (AOM) prescribing.

RESEARCH DESIGN AND METHODS

A prospective, multisite QI initiative was conducted from March 2023 to February 2024. Participating practices implemented interventions targeting clinician knowledge/skills, systems/workflow redesign, and patient engagement using Plan-Do-Study-Act cycles. Educational activities included case-based learning, implementation tools, and performance feedback. Sites abstracted deidentified electronic health record data at baseline and postintervention to assess the study outcomes; CME pre/post assessments measured educational outcomes, and qualitative data from QI sessions and site feedback were analyzed thematically. Patient-level outcomes were analyzed separately from the national CME learner outcomes.

RESULTS

Baseline data included 769 patients, and postintervention data included 699 patients. Improvements were observed in obesity diagnosis documentation (78.9–89.2%), multimodal care planning (28.8–54.2%; $P < 0.05$), and AOM prescribing (48.4–64.3%). The proportion of patients achieving weight loss within the prior 6 months increased from 46.0% to 70.7% ($P < 0.05$). Educational activities reached 18,799 clinicians nationally and improved knowledge and competence. Qualitative findings highlighted increased clinician comfort discussing weight and greater use of workflow tools.

CONCLUSIONS

This structured QI initiative was associated with improvements in obesity care processes and weight outcomes, supporting the feasibility of scalable CME, workflow, and patient engagement tools, while recognizing the limitations of a voluntary, uncontrolled design.

ARTICLE HIGHLIGHTS

• Why did we undertake this study?

Obesity remains underdiagnosed and undertreated despite guidelines and expanding treatment options, highlighting the need for scalable strategies to improve guideline-concordant care.

- **What is the specific question(s) we wanted to answer?**

Can a multisite quality improvement (QI) initiative integrating continuing medical education and workflow interventions improve obesity diagnosis, multimodal care planning, antiobesity medication use, and weight outcomes?

- **What did we find?**

The initiative was associated with improved obesity diagnosis documentation, greater use of multimodal obesity care plans, increased antiobesity medication prescribing, and more patients with documented weight loss.

- **What are the implications of our findings?**

Clinician education, workflow redesign, and patient engagement may help practices implement obesity guidelines, although the uncontrolled QI design limits causal conclusions.

Introduction

Obesity [AQ2](#) is recognized by the World Health Organization as a global epidemic, and [AQ3](#) its prevalence among U.S. adults exceeds 42% ([1](#)). Obesity is closely linked to a broad range of comorbid conditions, including diabetes, cardiovascular disease, stroke, certain cancers, and premature mortality in adults younger than 65 years of age ([2,3](#)). It is also associated with poorer mental health outcomes, reduced quality of life, and significant functional limitations ([2](#)). Even modest weight loss yields clinical benefit; reductions of 5–10% are associated with improvements in glycemic status, blood pressure, lipids, sleep apnea, and other obesity-related complications ([4,5](#)).

Health care professionals (HCPs) play a central role in identifying and managing obesity. A formal diagnosis of overweight or obesity is a critical first step in helping patients understand the biological and metabolic underpinnings of obesity and initiating evidence-based interventions to reduce weight ([6,7](#)). HCP diagnosis and counseling have been consistently associated with higher rates of weight loss attempts, greater likelihood of achieving clinically meaningful weight loss, and

more accurate self-perception of weight status. Despite this, many patients who meet diagnostic criteria for overweight or obesity do not receive a documented diagnosis or structured weight-management support (3,8).

Antiobesity medications (AOMs) are an important adjunct to lifestyle therapy and can help patients achieve clinically significant and durable weight loss. Contemporary guidelines recommend consideration of pharmacotherapy for individuals with BMI ≥ 30 kg/m² or ≥ 27 kg/m² with at least one weight-related comorbidity when potential benefits outweigh the risks (9–11). Newer AOMs, including glucagon-like peptide 1 receptor agonists and dual glucose-dependent insulinotropic polypeptide/glucagon-like peptide 1 receptor agonists, have demonstrated meaningful weight loss and improvements in cardiometabolic risk factors in clinical trials and real-world studies. However, use of AOMs in practice remains low; only 1–2% of eligible adults receive prescriptions, reflecting gaps in HCP awareness, comfort, and confidence regarding these agents (12–14). Despite the expanding therapeutic armamentarium, translation of evidence-based obesity care into routine practice remains inconsistent.

Multiple barriers limit the consistent delivery of guideline-concordant obesity care. HCPs report time constraints, limited reimbursement, uncertainty about effectiveness, lack of referral resources, and concerns about patient receptivity as reasons for not prioritizing obesity management in visits (3,15). Beyond clinician-level barriers, patient access challenges, including limited availability of trained HCPs and obesity specialists, as well as restrictive coverage policies and high costs of AOMs, may significantly constrain the real-world implementation of guideline-recommended obesity care, particularly among groups disproportionately affected by obesity (16–18).

Persistent weight stigma and misconceptions that obesity reflects personal failure rather than a chronic disease further undermine diagnosis, counseling, and therapeutic decision-making (19,20). At the same time, most people with obesity indicate they would welcome HCP-initiated conversations about weight and long-term treatment options, including pharmacologic and surgical interventions (21).

The Obesity Change Makers initiative was developed to address these gaps through a national,

multisite quality improvement (QI) program integrating guideline-based continuing medical education (CME). The aim of this study was to evaluate the association of this structured QI initiative with documentation of obesity, multimodal treatment planning, AOM prescribing, and weight outcomes across diverse U.S. clinical practices.

Research Design and Methods

Study Design

This was a prospective, multisite QI initiative conducted from March 2023 to February 2024. Practices were recruited via the Decera Clinical Education (formerly Clinical Care Options) database, engaging HCPs committed to QI to implement evidence-based obesity care strategies within their clinical settings. Participation was voluntary, and no nonparticipating comparison group was included. The participating practices formed a community of practice and used structured QI methods grounded in established principles of continuous professional development and practice-based learning, including explicit aims, measurement over time, and iterative testing of changes using Plan-Do-Study-Act (PDSA) cycles. Within this framework, practices planned targeted changes to obesity care processes, implemented these changes in routine clinical workflows, evaluated their effects using predefined process and educational measures, and refined approaches based on observed results. Educational components were designed to promote translation of guideline recommendations into daily practice through a combination of didactic content, case-based discussions, performance feedback, and practical implementation tools. Educational activities, the menu of change concepts, and patient/practice implementation resources were delivered through Decera Clinical Education and related program resources.

Because this initiative focused on practice-level process improvement using deidentified, aggregate data and did not involve experimental treatments or randomization, it was reviewed and determined to be exempt from institutional review board oversight as QI/non-human participant research at the coordinating center, Sterling Institutional Review Board (Atlanta, GA; exemption [AQ4](#) determination approved; protocol 15326-CYawn). Individual sites followed local policies for QI review and did not obtain individual informed consent.

Intervention Framework

Interventions were designed to address three identified clinical practice gaps: failure to diagnose and prioritize obesity management; underuse of AOMs in eligible patients; and limited, episodic, or noncollaborative weight management counseling. These gaps were identified during program planning through review of published literature, prior national surveys, and analysis of educational and practice data. To address these gaps, the initiative used a driver model organized around three interrelated domains: clinician knowledge and skills, systems and workflow, and patient engagement and support. During PDSA cycles, participating practices selected locally relevant change concepts, tested them in routine workflows, reviewed practice-level feedback, and refined implementation based on feasibility and early results.

Knowledge and Skills

Educational activities focused on strengthening clinical understanding of obesity as a chronic, relapsing disease and improving provider competence in evidence-based recommendations for diagnosis, staging, and treatment. Content addressed the pathophysiology of obesity and its complications as well as the indications, mechanisms of action, efficacy, and safety of available and emerging AOMs. Activities also emphasized communication skills, including strategies to reduce weight stigma, motivational interviewing techniques, and shared decision-making.

Learning formats included live or virtual sessions, case-based discussions, and point-of-care tools such as electronic health record (EHR)-embedded talking scripts, medication comparison charts, and patient educational materials. These educational and implementation resources were distributed through a centralized Decera Clinical Education platform and associated resource hub so that participating practices could access common materials while adapting them locally.

Sessions were developed and facilitated by expert faculty in obesity medicine, who contextualized evidence-based recommendations through real-world clinical scenarios and guided interactive discussion. Educational design followed principles associated with adult learning theory and improved clinical behavior change, including interactivity, relevance to practice, and linkage to real

performance data (22).

Systems and Workflow Redesign

Participating sites implemented systems-level interventions tailored to their local context, selected from a standardized menu of change concepts. Common strategies included integration of EHR documentation shortcuts, such as obesity smart phrases and checklists, to prompt HCPs in documenting obesity diagnoses, nutrition and health coaching referrals, pharmacotherapy discussions, and assessment of bariatric surgery eligibility. Multimodal obesity care templates were embedded within progress notes to support standardized documentation of lifestyle counseling, pharmacotherapy, and referral plans in a single, structured section.

Additional workflow changes included processes to ensure BMI calculations and obesity diagnoses were consistently captured and [AQ5](#) reconciled in medical records, standardized follow-up intervals and recall processes for weight-management visits, and internal processes to support prior authorization and patient assistance for AOMs, reflecting known access barriers. Examples of changes tested through PDSA cycles included smart phrases to prompt obesity diagnosis and care plan documentation; multimodal care templates; referral workflows for dietitians or bariatric services; staff workflows for insurance documentation; and processes for discussing medication coverage, cost, prior authorization, and patient assistance options.

Patient Engagement and Support

To address deficits in patient-centered communication and ongoing support, sites implemented strategies aimed at enhancing engagement beyond episodic office visits. These included group visits or virtual support groups focused on nutrition, physical activity, sleep, stress management, and measures beyond BMI, modeled on evidence supporting structured lifestyle programs and peer support. Patient educational materials were individualized through EHR-based smart phrases and covered topics such as medication administration, self-monitoring, and recognition of adverse effects.

Sites also strengthened referral pathways to dietitians and behavioral health and bariatric surgery

services, in line with guideline-recommended multimodal management. Shared decision-making frameworks were explicitly incorporated to support collaborative goal setting and individualized treatment planning.

Measures

Four primary quality measures were selected based on the needs assessment, guideline recommendations, and evidence linking these processes to weight and health outcomes. Measures included the gap between patients meeting obesity criteria and actual documented obesity diagnosis; the presence of a documented multimodal obesity care plan incorporating lifestyle, pharmacologic, and/or procedural components; appropriate prescribing of AOMs among eligible patients; and evidence of weight change. Weight outcomes were assessed as the percentage of patients with documented weight loss in the prior 6 months and change in mean BMI.

Data Collection and Analysis

Sites abstracted data from EHRs at baseline and after the intervention period using standardized templates. Data included patient demographics, BMI, obesity-related diagnoses, documentation of care plan components, AOM prescriptions, and recent weight changes. Depending on site capability, data abstraction was completed via automated EHR reports or manual record review. The baseline and postintervention abstractions were cross-sectional samples drawn from the same participating practice populations and were not required to include the same individual patients. Eligible records included those for adults with BMI ≥ 30 kg/m² during the abstraction period. Denominators differed across measures because of variation in EHR data availability, site reporting capacity, and documentation completeness.

Quantitative analyses were conducted for two distinct outcome domains: 1) CME educational outcomes and 2) practice-level QI measures. CME educational outcomes were assessed separately using pre- and postactivity learner assessments embedded within educational activities, evaluating changes in knowledge, competence, and intent to change practice. Descriptive

statistics were used to summarize learner performance before and after participation.

For QI measures, exploratory inferential analyses were conducted to compare baseline and postintervention measures, with *P* values reported where appropriate. These analyses were not powered for formal hypothesis testing and were interpreted descriptively. Because the initiative did not include randomization, component-level assignment, or a nonparticipating comparison group, analyses were used to describe changes associated with participation rather than to establish causal effects of the overall initiative or any individual intervention component. Where sample sizes permitted, exploratory subgroup analyses examined changes in documentation among sites with low baseline diagnosis rates and changes in AOM prescribing among sites with low initial pharmacotherapy use.

Qualitative data from QI coaching sessions, learning collaboratives, and site feedback were analyzed using thematic review to identify common facilitators, barriers, and implementation strategies related to diagnosis, AOM use, and patient engagement, with attention given to how sites addressed previously described gaps and barriers in obesity care. To support this process, a generative artificial intelligence tool (ChatGPT; OpenAI, San Francisco, CA [paid version 5.2]) was used only to assist with preliminary organization and summarization of deidentified qualitative text. All artificial intelligence–assisted outputs were reviewed, verified, and interpreted by the authors, and all final themes, analytic decisions, and manuscript conclusions were determined by the authors.

Results

Participant and Learner Characteristics

Twenty-one U.S. clinical sites participated in the QI initiative for adults with obesity, defined as patients with BMI ≥ 30 kg/m² at baseline and after the intervention period. Baseline abstraction included 769 patients, and postintervention abstraction included 699 patients from the same practice populations. The clinical sites represented a range of practice settings, including primary care, endocrinology, women's health, residency training clinics, community health centers, a

community hospital, and a pharmacy-based service. Available practice-level demographic variables included age, BMI, and diabetes status; other patient demographic variables were not consistently available across sites and therefore could not be summarized reliably. Because abstraction samples were cross-sectional, differences between baseline and postintervention patient characteristics may reflect sampling variation as well as changes in practice populations.

The educational program reached a large national audience of HCPs. Across all educational activities, a total of 18,799 unique learners participated, including pharmacists (26.4%), advanced practice providers (22.9%), physicians (18.2%), pharmacy technicians (14.6%), nurses (8.7%), and physician associates (4.1%). A majority practiced family medicine (45.0%), and others practiced internal medicine (27.9%) or endocrinology (16.5%).

Educational Reach and Engagement

Educational content was delivered across multiple formats, including podcasts, slide sets, PDFs, and Community of Practice webinar sessions. Podcasts, which were subsequently converted into text-based modules and video content, reached 354 learners. Downloadable PDF tools, including the obesity care roadmap, were accessed by 2,075 learners, with substantial secondary engagement reflected in downloads and follow-up actions.

CME Knowledge and Competence Outcomes

Pre- and postassessment data demonstrated consistent improvements in learner performance across multiple clinical domains related to obesity management. Across six representative assessment questions, mean pretest scores ranged from 46% to 79.7%, indicating variable baseline knowledge and confidence. Posttest scores increased across all items, ranging from 88.6% to 95.5%, reflecting substantial gains in applied knowledge and clinical decision-making.

Notably, the largest relative improvement was observed for questions assessing appropriate selection of candidates for AOMs, with mean scores increasing 42.6% pretest to posttest. Improvements were also observed in questions addressing evidence-based diagnosis and treatment selection, appropriate identification and use of AOMs, and patient-centered care

planning, including application of shared decision-making and multimodal management strategies.

Learner-reported outcomes further supported translation into practice. Among respondents, 53% indicated intent to implement changes in their clinical practice, and 46% reported increased awareness in their approach to obesity management. When asked about specific planned changes, learners most commonly identified applying updated guidelines (59%), educating other health care team members (40%), modifying team processes (34%), and changing prescribing practices (19%). [Table 1](#) summarizes the CME outcome domains and reported values of change or postactivity intent where available.

Note: The table layout displayed in 'Edit' view is not how it will appear in the printed/pdf version. This html display is to enable content corrections to the table. [Please click here to view table layout.](#)

Table 1 CME educational outcome summary

Alternate Text: A table summarises Outcome domain, Finding, Baseline or preactivity, Postactivity, and Reported change or interpretation. Knowledge and competence scores increase from 46.0 percent to 79.7 percent before the activity to 88.6 percent to 95.5 percent after the activity. Mean scores for candidate selection increase by 42.6 percentage points. After the activity, 53 percent report intent to change practice and 46 percent report increased awareness. Planned changes include applying guidelines, educating team members, modifying team processes, and changing prescribing practices.

Outcome domain	Finding		Reported change or interpretation
	Baseline/pre activity	Postactivity	
Knowledge/competence across six representative assessment questions	Mean pretest scores ranged from 46.0% to 79.7%	Mean posttest scores ranged from 88.6% to 95.5%	Improvement observed across all assessed items
Appropriate selection of candidates for AOMs	Pretest performance assessed within CME activity	Posttest performance assessed within CME activity	Mean scores increased 42.6 percentage points from pretest to posttest

Learner intent to change practice	Not applicable	53% of respondents reported intent to implement practice changes	Supports potential translation of education into clinical workflows
Learner-reported awareness and planned changes	Not applicable	46% reported increased awareness; planned changes included applying guidelines (59%), educating team members (40%), modifying team processes (34%), and changing prescribing practices (19%)	Reported planned changes aligned with targeted QI domains

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QI Outcomes

Practice-level QI outcomes were assessed separately. Improvements were observed across all measures, including documentation of obesity in medical records, use of multimodal obesity care plans, prescribing of AOMs, and proportion of patients achieving weight loss over the prior 6 months. [Table 2](#) summarizes baseline and postintervention performance for these quality measures. Given the voluntary, uncontrolled QI design, these results are reported as observed changes within participating practices and should not be interpreted as definitive evidence of causality. Differences in baseline characteristics between abstraction periods likely reflect sampling variation inherent to cross-sectional data collection rather than true population shifts.

Note: The table layout displayed in 'Edit' view is not how it will appear in the printed/pdf version. This html display is to enable content corrections to the table. [Please click here to view table layout.](#)

Table 2 Practice [AQ10](#) level QI outcomes

Alternate Text: A table summarises Data and metric, Data with Baseline and Final values, and Difference. Average age changes from 50.0 to 50.3 years. The proportion of patients with diabetes changes from 30.5 percent to 37.9 percent. Average B M I decreases from 38.3 to 36.4 kilograms per square metre. Quality metrics increase from baseline to final values. The difference is a decrease of 1.9 for average B M I

and increases of 10.3, 25.3, 15.9, and 24.7 percentage points for quality metrics 1 through 4. P values are below 0.05 for Q M 2 and Q M 4.

Data/metric	Data		Difference
	Baseline	Final	
Average age, years	50.0	50.3	
Proportion of patients with diabetes, %	30.5	37.9	
Average BMI, kg/m ²	38.3	36.4	−1.9 (<i>P</i> = 0.145)
QM1: proportion of patients in whom obesity was in medical record, %	78.9	89.2	+10.3 (<i>P</i> = 0.151)
QM2: proportion of patients with obesity care plan including multimodal interventions, %	28.8	54.2	+25.3 (<i>P</i> < 0.05)
QM3: proportion of patients prescribed AOMs, %	48.4	64.3	+15.9 (<i>P</i> = 0.071)
QM4: proportion of patients who lost weight over last 6 months, %	46.0	70.7	+24.7 (<i>P</i> < 0.05)
QM, quality metric.			

Qualitative Findings From Practice-Based Discussions

Qualitative analysis of faculty-led podcast discussions and Community of Practice webinar sessions identified several recurring themes related to implementation of obesity care improvements, as reported in [Table 3](#). These themes reflected practical challenges that facilitators encountered during real-world practice transformation.

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Table 3 Representative qualitative feedback from group podcast discussions

Alternate Text: A table summarises Group podcast, Intervention domain, Participant role, Theme, and Representative quote. Groups 1 to 5 cover systems and workflow redesign, patient engagement and support, and knowledge and skills. Participants include attending physicians, internal medicine physicians, physician assistants, paediatric physicians, and primary care physicians. Themes include what went well and opportunities for improvement. Quotes describe benefits, challenges, patient

engagement, follow up, data use from electronic medical records, and sustaining treatment efforts.

G r o u p p o d c a s t	Inter venti on doma in	Participant role	The me	Representative quote
1	Systems and workflow redesign	Teaching attending, internal medicine (academic clinic)	What went well	"Because it's formulated as a checklist, it's easy to ease a patient into the topic and make sure guideline-based questions are being asked."
				"It's kind of heartwarming to see that such a simple and small smart phrase tagged onto the end of a progress note has had such a beneficial and tangible effect on our patient population."
			Opportunities for improvement	"There's a bit of a learning curve with teaching residents how to access the smart phrase and how to properly use it. If we were to try this again, it would be a good idea to provide something like a script for the residents to use outside of the regular lecture."
				"Right now, the checklist appears in every progress note. It would be really nice if it only showed up when certain parameters were met, so you don't have to click through all the no's when someone doesn't meet criteria."
2	Patient engagement and support	Obesity medicine physician (private practice)	What went well	"It really got me thinking about how I can help support my patients on a daily basis, a weekly basis, just over their lifetime. Obesity is a chronic disease, and patients need ongoing support even outside of medical visits."
				"We started offering chat groups related to nutrition, physical activity, sleep, stress, and nonscale victories. Patients can post at any time, share struggles or wins, and support each other in a nonjudgmental environment."
			Opportunities for improvement	"Initially, I started off a little too big and had too many groups. I think it's better to start smaller and scale up rather than do too much, because there's also only one of me."

				"One of the challenges was getting patients to show up to live meetings. Many wanted the recorded version afterward, and engagement in real time was difficult with just two or three people showing up."
3	Knowledge and skills	Physician assistant, internal medicine (private practice)	What went well	"The first thing is I always ask patients about their weight. I don't typically ask, 'Are you happy with it?' as much as, 'How stable is it?' That usually gets the conversation going and helps me understand where they're at before we jump into making changes."
				"I really try to keep it very individualized to the patient—the age of the patient, the motivation of the patient. We start with small, realistic goals and build from there, based on what they're already doing."
			Opportunities for improvement	"Other things that I have done personally with patients, that I would like to probably find some way to do it at a bigger scale, is sending...affirmative text messages...or just checking in."
				"Getting patients back in consistently for follow-up can be difficult. I want to see them every 6 weeks, but keeping that regular cadence is sometimes a hurdle."
4	Knowledge and skills	Internal medicine and pediatrics physician (community-based practice)	What went well	"We run through how to give the injection, and then we actually show them the injection so that they are doing it physically themselves in the office. I think that overcomes the needle phobia barrier and also the phobia of the medicine and what to do with them when they get home. So they...have already started their journey before they have left the office, which is very powerful for them."
				"Most recently, with the advent of some other more powerful medications, we have been very pleasantly surprised with the results."
			Opportunities for improvement	Synthesized finding: Challenges included integrating newer pharmacologic therapies into long-standing multimodal care approaches, maintaining longitudinal management across diverse age groups, and sustaining obesity treatment efforts beyond medication alone.
5	Knowledge and skills	Primary care physician, rural family medicine practice	What went well	"We really got down to the basics and did things like root cause analysis and fishbone diagrams. That helped us identify low-hanging fruit that would have the greatest impact on our patients."
				"Just by putting obesity on the problem list, it brought up more conversations. Patients would come in and ask about it, and it got addressed more often than it ever had before."
			Opportunities for improvement	"Getting accurate data from our EMR took quite a bit of a learning curve. Figuring out where to get the right reports and the right numbers was one of the more challenging parts."

				"Keeping everyone engaged over time was difficult. This isn't something you fix once—it's an ongoing process, and maintaining that mindset was a challenge."
EMR, electronic medical record.				

Conclusions

Participation in this multisite QI initiative was associated with improvements in obesity diagnosis documentation and care management processes among participating practices. The findings suggest that combined educational, communication, and workflow support strategies may help practices address gaps in obesity care; however, the initiative was not designed to isolate the effects of knowledge transfer, conversational tools, workflow redesign, or patient engagement strategies individually. Accordingly, these results should be interpreted as descriptive QI findings rather than causal evidence of specific intervention component effectiveness.

This multisite QI initiative demonstrates that improving obesity care requires more than knowledge transfer alone; it depends on equipping clinicians with practical conversational tools and embedding guideline-concordant care into routine clinical workflows. At a high level, our findings suggest that when clinicians are provided with shared language to initiate weight-related discussions, alongside system-level supports that normalize obesity diagnosis and treatment, meaningful changes in care processes can occur, even within time-constrained clinical settings.

This interpretation adds nuance to existing literature on obesity education, which has largely emphasized disease knowledge, counseling frequency, or isolated documentation outcomes. In contrast, the current initiative highlights the importance of how obesity conversations are initiated and operationalized, suggesting that conversational readiness may be a critical, underappreciated lever for improving guideline uptake in the context of obesity as a chronic, relapsing disease. Because the study lacked a comparison group and did not vary exposure to specific intervention elements, the relative contribution of conversational tools versus workflow supports cannot be determined.

Prior obesity-focused QI projects have demonstrated modest improvements in screening,

documentation, or referral patterns, often through single-site interventions, EHR prompts, or brief educational sessions. Although these approaches have value, many lack longitudinal reinforcement, mixed-methods evaluation, or explicit integration of education with practice-level change strategies that address both clinician capability and system readiness.

This initiative contributes several distinct elements to the existing landscape: 1) a heterogeneous, multisite practice sample, including community-based and diverse clinical settings, enhancing generalizability beyond academic centers and specialty clinics; 2) integration of structured CME with practice-embedded QI, allowing education to directly inform workflow redesign rather than function as a standalone intervention; and 3) mixed-methods evaluation, combining quantitative changes in care processes and prescribing patterns with qualitative insights into how clinicians and teams translated education into action.

Together, these features distinguish this program from prior obesity QI efforts and suggest a model that is both scalable and adaptable across varied health care environments where time, staffing, and resources are constrained. At the same time, voluntary participation may have selected practices with greater baseline readiness or interest in obesity care, limiting generalizability to less-resourced or less-engaged settings. To support sustainability and broader dissemination of intervention tools, clinicians were directed to a publicly accessible obesity QI resource hub containing enduring educational modules and implementation-ready resources (www.clinicaloptions.com/Obesity/ResourceHub). By translating the intervention components into enduring, implementation-ready resources, including documentation templates, multimodal care planning tools, pharmacotherapy guidance, and patient engagement materials, the hub established a mechanism for sustainability and broader dissemination. This infrastructure extends the reach AQ6 of the initiative, enabling clinicians beyond the original participating sites to independently adopt and operationalize evidence-based obesity care processes within their own practice settings.

The parallel assessment of CME outcomes provides context for interpreting the observed practice-level changes. Pre- to postassessment gains across multiple clinical scenarios indicate that participating HCPs not only gained factual knowledge but also applied decision-making in

obesity management, including guideline-based diagnosis, treatment selection, and AOM use. Importantly, learner-reported intentions closely aligned with observed practice changes, particularly in documentation, guideline application, and AOM prescribing workflows. However, CME outcomes and practice-level outcomes were collected through distinct evaluation components and could not establish that learner improvements directly caused patient-level changes.

Qualitative findings provide insight into the mechanisms underlying these changes. Participants described normalization of obesity diagnosis, increased comfort initiating discussions, and greater use of team-based workflows as key drivers of implementation. These themes suggest that providing clinicians with structured language and shared frameworks for patient-centered conversations may reduce stigma-related avoidance and uncertainty, enabling more consistent engagement of obesity as a chronic disease.

Additionally, findings point to the importance of technology-enabled supports such as smart phrases, documentation prompts, and prescribing triggers to sustain and scale improvements. Embedding these tools within existing EHR systems may lower cognitive and time burdens, making guideline-concordant obesity care more feasible in routine practice. Practice discussions also highlighted implementation supports related to reimbursement and access, including documentation for coverage, prior authorization workflows, patient assistance resources, and referral pathways; however, the initiative did not systematically measure reimbursement outcomes or medication affordability.

Several limitations should be considered. This was a nonrandomized QI initiative without a control group, and participation was voluntary, introducing potential selection bias. Participating practices may have been more motivated, better resourced, or more aware of evolving obesity guidelines than nonparticipating practices. The before-and-after design also did not account for secular trends during the study period, including increasing clinician and patient awareness of newer AOMs, media attention to obesity pharmacotherapy, and evolving treatment expectations. The patient-level sample was modest relative to the national learner audience, and baseline and

postintervention record abstractions were cross-sectional rather than paired at the patient level. Demographic data beyond age, BMI, and diabetes status were not consistently available across sites. The initiative also was not designed to determine which intervention components were most effective, and longer-term sustainability, weight outcomes beyond the assessed period, reimbursement effects, and medication affordability were not systematically evaluated. Outcomes were assessed over a relatively short period, introducing temporal bias, because longer-term effects on weight and metabolic outcomes were not evaluated.

In conclusion, participation in this structured multisite QI initiative was associated with improvements in clinician readiness and selected processes of guideline-concordant obesity care among participating practices. Health systems seeking to improve obesity care may consider structured conversation scripts, EHR-based documentation prompts, standardized multimodal care templates, referral workflows, and access support processes as potential implementation strategies. Because this initiative was voluntary and uncontrolled, future evaluations using comparison groups, longer follow-up, and component-level assessment are needed to determine the durability of changes and the relative contribution of specific educational, workflow, patient engagement, and reimbursement support strategies.

Article Information

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During [AQ7](#) the course of preparing this work, the authors used ChatGPT in order to support the thematic analysis of the qualitative portion of this manuscript and in the preparation of the manuscript. After using this tool/service, the authors formally reviewed the content for its accuracy and edited it as necessary. The authors take full responsibility for all the content of this publication.

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Duality of Interest

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Author Contributions

C.Y. collected and analyzed data, created the initial manuscript draft, and revised the manuscript. S.D. reviewed and edited the manuscript. J.K., R.B., and S.N. contributed to discussion and reviewed and edited the manuscript. P.L. researched data, contributed to discussion, and reviewed and edited the manuscript. All authors accept responsibility for the manuscript findings and narrative. C.Y. is the guarantor of this work and, as such, had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

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Author Query

1.

Query [AQ1] : To support accessibility, alternate text (Alt text) has been generated by artificial intelligence and added to all figures and tables. Alt text is used only by screen readers for individuals with visual impairment and does not appear in the published article. Please review and revise as needed the Alt text descriptions provided within your article.

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