The Joys and Challenges of Delivering Obesity Care: a Qualitative Study of US Primary Care Practices

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BACKGROUND: Obesity is of epidemic proportion in the USA but most people with obesity do not receive treatment.

OBJECTIVE: To explore the experience of providing obesity management among primary care clinicians and their team members involved with weight loss in primary care practices. The study's focus was on examining the use of the Medicare payment code for intensive behavioral therapy for obesity (IBT), but other obesity management services and payment mechanisms were also studied.

DESIGN/PARTICIPANTS: We conducted 85 interviews of clinicians (physician, advanced practice clinicians, registered dietitian, or other) practicing in primary care practices. Interviews gathered information about treatment approach to obesity, barriers, and facilitators to providing obesity care including the handling of billing and reimbursement (especially use of the IBT code), personal beliefs about the appropriateness of primary care providing weight loss services, and recommendations for improving weight management in primary care practice. The analysis was conducted using a grounded theory hermeneutic editing approach and the constant comparative method.

KEY RESULTS: Seventy-five interviews were included in this analysis. We identified three primary themes: (1) clinicians and staff involved in obesity management in primary care believe that addressing obesity is an essential part of primary care services, (2) because providing obesity care can be challenging, many practices opt out of treatment, and (3) despite the challenges, many clinicians and others find treating obesity feasible, satisfying, and worthwhile.

CONCLUSIONS: Treating obesity in primary care settings poses several challenges but can also be very satisfying and rewarding. To improve the ability of clinicians and practice members to treat obesity, important changes in payment, education, and work processes are necessary.

KEY WORDS: obesity; primary care; qualitative research; weight management; reimbursement; satisfaction.

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BACKGROUND

Obesity is of epidemic proportion in the USA. The current national prevalence of obesity is over 35%¹, with measurement-based data indicating a national rate of obesity of almost 40%². In addition, extreme obesity (body mass index (BMI) greater than or equal to 40) doubled between 2000 and 2010³. Obesity is associated with countless comorbidities including diabetes, hypertension, arthritis, heart disease, and sleep apnea. An estimated \$190 billion is spent annually in the USA on the treatment of obesity-related disease⁴.

Since 2003, the United States Preventive Services Task Force has recommended that obesity screening and intensive behavioral counseling be provided in primary care settings^{5–7}. However, only a fraction of obese patients report discussing obesity or receiving a behavioral intervention for weight loss from their primary care clinicians^{8,9}. One explanation for this is that most medical students and residents receive little to no formal training in nutrition and obesity management, and those who do often express a need for more training^{10–12}. In addition, some evidence-based approaches, such as weight-loss medication and bariatric surgery, continue to be controversial; many clinicians are not aware of specific referral guidelines or believe lifestyle change is the only appropriate treatment^{13–15}. Also, many behavioral treatment approaches are time- and resource-intensive, making them difficult to implement and sustain in primary care¹⁶. Finally, clinicians face historically low or nonexistent reimbursement for clinical weight management services^{17–19}.

In 2011, the Center for Medicare and Medicaid Services began offering reimbursement for intensive behavioral therapy (IBT) for obesity, allowing designated health care clinicians to bill for IBT for obese patients. The benefit allows for 15-min visits once per week for 4 weeks, biweekly visits for months 2 to 6, and then once monthly for 6 months. The visits must be conducted by a physician, nurse practitioner, or physician's assistant in internal medicine or family medicine settings or can be provided by a registered dietitian (RD) and be billed "incident to" care provided by primary care clinicians²⁰.

However, the uptake of IBT by primary care clinicians has been low²¹.

In the face of these barriers, we wondered why some clinicians do provide weight management and whether they perceive their efforts as effective. We were also curious about the emotional and financial burden of caring for obese patients. In this paper, we explore these questions from the perspective of clinicians and other care team members who provide or have provided weight loss services to provide insights into overcoming the challenges of implementing weight management in primary care.

METHODS

We conducted this multi-methods study to better understand the use and non-use of the IBT benefit. This paper reports the qualitative findings of this study. The Colorado Multiple Institutional Review Board (IRB) as well as the IRBs at Michigan State University and Duke University approved this protocol.

Participant Recruitment

To identify primary care clinicians who had been or were currently billing for IBT for obesity (our key selection criteria), we used the publicly available Medicare Provider Utilization and Payment Data files²² to identify all qualifying medical clinicians that had submitted 11 or more unique person claims for the IBT for obesity benefit between 2012 and 2015 (the complete data set at the time). We then attempted regional variation by randomly selecting practices from 14 states representing the four US Census regions²³. Recruitment included introductory letters and a study brochure, followed by phone calls. Unfortunately, contact information in the dataset was often incorrect and it was difficult to reach clinicians, resulting in a very low response (7.6 % response rate). Therefore, we contacted leaders of practice-based research networks, using the same approach to introduce the study and request participation, resulting in a higher response to our requests. Details of this recruitment process are found elsewhere²⁴. However, given the qualitative nature of this study and focus on practices providing obesity management, we were not trying to be representative of US practices (i.e., this was a convenience sample).

Data Collection and Instruments

We first used a written survey (paper or online) to collect descriptive information about the practice, the types of weight loss services offered, and information on billing and reimbursement practices (Appendix A in the Supplementary Information). We then invited a single respondent from these practices to participate in a semi-structured telephone interview²⁵. The research team

developed an interview guide covering the following topics: treatment approach to obesity, barriers and facilitators to providing obesity care, billing and reimbursement, personal beliefs about the appropriateness of primary care providing weight loss services, and recommendations for improving weight management in primary care (see Appendix B in the Supplementary Information). After pilot testing, interviews were conducted by experienced researchers. Interviews lasted 30–60 min and were audio recorded and professionally transcribed. Participants were compensated with a \$50 gift card. Informed consent was obtained prior to the survey and the interview. Of practices that had completed surveys (291), 243 were asked to complete an interview (some practices where only RDNs were available were not invited as we did not want to oversample RDNs). The response to completing the interviews out of the requested was 85/243 (35%).

Data Analysis

Survey methods and results are available elsewhere²⁴. The core qualitative analysis team included a practicing physician, clinical psychologist, and health services researcher. The analysis was conducted using a grounded theory hermeneutic editing approach²⁵, which features results. Codes for analysis are not determined a priori but instead identified as key issues emerge. As the process proceeds, the thematic elements emerge from and are considered “grounded” in the data. We chose this method because of the paucity of qualitative work in this area and the desire to stay inductive, as well as the usefulness of this method in primary care exploratory research²⁶. ATLAS.ti 8.3 (Scientific Software Development GmbH, Berlin) facilitated data organization. The qualitative team read selected transcripts and independently identified potential codes. Researchers discussed their initial codes and refined them using a constant comparative method and review of the literature, using an iterative process to develop the final codebook. Next, the team independently coded the same documents and compared them until a high degree of conceptual inter-rater reliability was established. Then the documents were divided among the team and coded independently. Following coding of all transcripts, quotation, and code co-occurrence reports were generated and reviewed by specific code and code groups. Additionally, the data were examined by the IBT for obesity usage code (present, past, and never used) and by interviewee type (physician, advanced practice clinicians (nurse practitioners or physician assistants), RD, or other (CEO, program coordinator, practice manager, medical director, program director, resident, vice president). Corroborating and legitimizing occurred by comparison with the literature and sharing emergent themes with the overall study team and selected primary care clinicians as a check on face validity.

RESULTS

Eighty-five interviews were conducted and 10 were eliminated from the data set due to the respondent not representing a primary care practice or to incomplete interview data. Table 1 displays the characteristics of the 75 interviews. Across the data, patterns of themes were consistent across groups; therefore, the thematic results were kept together with evidence of differences by group (IBT user vs. non-user) noted. Example quotations for each theme are listed in Table 2 and referenced in parentheses under themes.

Theme 1: Addressing obesity is as an essential part of primary care

This first theme was simple and straight-forward. All respondents, regardless of whether they were providing obesity specific care or not, endorsed primary care as a place where patients should be offered help with weight loss because of the high prevalence and the effects of obesity on quality of life and a multitude of comorbidities, as well as the potential for prevention of these comorbidities through weight loss (quotation 1). Many respondents believed that addressing obesity was within their scope of practice; some found addressing obesity so important that they made it their clinical focus (quotation 2). Clinicians emphasized the important role that primary care plays in preventing chronic conditions and made the connection that reducing weight in obese patients can alleviate chronic conditions (quotation 3).

Theme 2: Due to several challenges, many clinicians opt out of specifically providing weight management in their practice

Table 1 Characteristics of Interview Participants, Practices, and Experience Billing for IBT for obesity

Characteristic, N = 75 total interviews		N (%)
Practice location	South	29 (39)
	West	20 (27)
	Northeast	9 (12)
	Midwest	17 (22)
Size of practice (by clinicians number)	Small (< 5 clinicians)	30 practices
	Moderate-large (5 ≥ clinicians)	45 practices
Clinician type	Physician	50*
	Advanced practice clinicians	2**
	Registered dietitian	8
	Other	15†
Use of IBT for obesity code—individual	Current	36 (48)
	Previous but not current	8 (11)
	Never	18 (24)
	Not sure/unknown	13 (17)
Use of IBT for obesity code—group	Current	5 (7)
	Previous but not current	2 (3)
	Never	58 (77)
	Not sure/unknown	10 (13)

*Internal medicine (16), family medicine (16), unknown (18)

†CEO (1), program coordinator (2), practice manager (5), medical director (3), program director (2), intern resident (1), vice president (1)

**NP (1), PA (1)

Despite universal agreement on the importance of treating obesity, many clinicians do not offer weight management in their practice. Although all respondents experienced challenges, those who were trying to fit weight management into standard primary care practice without a specific system for care described it as more difficult than those who had a specific or separate program devoted to weight management. Four specific challenges individually or collectively created a situation where practice leaders give up on providing weight management, either after trying and struggling to do so, or before they even start.

Challenge #1—I don't know how to comprehensively tackle this problem!

Many respondents reported a lack of clinician training on how to effectively help patients lose weight and keep it off (quotations 4 and 5). Even some dietitians described inadequate preparation to counsel for weight loss as patients often have comorbid behavioral health issues. Many expressed that helping patients lose weight requires more than providing information on healthy lifestyles and did not feel equipped to support effective behavior change (quotation 6). Several mentioned a desire for more clinical training to increase their knowledge about evidence-based weight management. Although there are many treatments available, there was skepticism about the safety and/or feasibility of certain diet plans, weight loss medications, and surgical options (quotation 7). Beyond patient treatment, respondents expressed a lack of knowledge about how to provide weight management in their practice such as how to structure patient appointments, how to bill, and how to organize workflows (quotation 8).

Challenge #2—This is a complex, multifaceted problem

Respondents often described weight management as complex and they recognized that treating obesity through behavior change requires long-term management, like any other chronic disease (quotation 9). Thus, a system for addressing obesity needs to be developed. Standard 15-min visits are often too short to address the medical and behavioral health issues and treatment options while using motivational interviewing or behavior change techniques for obesity (quotation 10). Many believe that effective weight loss requires a team of clinicians, including behavioral health professionals, RDs, and health coaches. However, many also identified this as difficult or impossible for general primary care practices to implement given lack of reimbursement for such comprehensive services. Respondents who were using a team approach to weight management in their practice often had transitioned to providing specialized obesity care rather than full-spectrum primary care (quotations 11 and 12).

Challenge #3—I simply don't get paid enough to provide weight management compared to other services and it is a huge hassle to try

Table 2 Themes and Example Quotations

Theme/challenge	Example quotation (interview number, role, and type of practice follow quotation.)
Theme 1: Addressing obesity is as an essential part of primary care	1. "It's just part of my regular family medicine practice to counsel and treat obesity...obesity is related to many health conditions, and also to emotional, psychological issues that patients face how they feel about themselves as well as how their physical health is, so we need to address it." #40, Physician in standard primary care practice
	2. "[In the past] I would say what every other doctor says—you need to lose weight and exercise more, and the people would say, 'Yeah. I know.' And they would come back next year, and they would be the same weight or heavier. So I mean I was 4 years and 3 months into a 5-year partnership buy-in when I basically decided that I didn't want to keep practicing medicine this way, and I just left." #29, Physician in obesity focused practice
	3. "We do a lot of preventative care because we want to provide answers for our patients, and weight loss is one of them." #81, Physician in standard primary care practice
Theme 2: Due to several challenges, many clinicians opt out of specifically providing weight management in their practice	
Challenge #1—I don't know how to comprehensively tackle this problem!	4. "I still think that the amount of training that medical students and primary care residents are getting now is pretty skinny, and until something really happens about that—really embraced better, you're still gonna have the problem of supporting it in the practice." #64, RD in a family medicine residency training practice
	5. "I don't have the training to give them what they really need—I mean I can start the conversation, sure, and I've had plenty of patients take what I've told them and run with it, and do really well for themselves, but most people they need a health coach; they need a dietitian." #68, Physician in standard primary care practice
	6. "A lotta times I feel like they know what foods are healthy and how much they should be eating and everything, and so it's more of a behavioral issue, I encourage them to seek out behavioral counseling through a therapist" #54, RD in standard primary care practice
	7. "Well, my take—I don't find that they're [medications] durable. I mean, you can't keep people on these for their whole life. If they don't learn lifestyle changes, whatever they've lost they'll put right back on when you take 'em

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Table 2. (continued)

Theme/challenge	Example quotation (interview number, role, and type of practice follow quotation.)
	off" #6, Physician in standard primary care practice
	8. "And so, again, that's been a kind of a workflow challenge for the clinicians just to think about reviewing those behavioral health notes too—another piece of information to review either during the visit or in our pre-visit huddles that we do now too—it's still a work in progress. We're trying to figure out the right amount of time, who needs to be at the huddles, to have the greatest impact." #63, Physician in standard primary care practice
Challenge #2—This is a complex, multifaceted problem	9. "I think we just have to recognize this is a lifelong, relapsing, chronic disease. There have to be treatments available through a lifetime, and when you look at the data of long-term weight maintenance it's really poor...this is complicated, and it's multi-factorial, and it's difficult, and it isn't about what you eat." #22, Physician in obesity focused practice
	10. "Oh, that's hard because everyone is so busy, and I feel like the nutrition's pushed down the side. So, to make that more relevant I think what needs to happen is that a doctor has to take a chance on adding a dietitian to the team, and then hopefully seeing the improvements in patients when they do see you." #30, RD working in standard primary care practice
	11. "We're still learning about all the factors that sort of drive obesity. Our behavioral health people are helping us. We've got a little bit around history of trauma and other things that can relate to adult obesity, and so we're sort of taking a deeper dive into not only helping people with their obesity but trying to get more into the person's head and figure out what's really driving their eating behaviors." #63, Physician in standard primary care practice
	12. "It's got to be a transformational process. You gotta do behavioral approaches. You gotta do physical activity. You gotta do lifestyle coaching, and counseling, and the whole kit and caboodle, so—and I guess I would just say that there's no one treatment approach that's perfect. It's just individualizing treatment for the person." #22, RD in standard primary care practice
Challenge #3—I simply don't get paid enough to provide weight management compared to other services and it is a huge hassle to try	13. "Reimbursement's real important. So it's—you know, it's an important thing, but, you know, it's hard to get physicians to do it if they're not getting paid." #11,

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Table 2. (continued)

Theme/challenge	Example quotation (interview number, role, and type of practice follow quotation.)
	Physician in standard primary care practice 14. "I believe the most frustrating part of this is some insurers, they pay for the visit if the BMI's over 30, but now we do a good job and the BMI's under 30, now they won't pay for the visit anymore because they're not obese. If we were managing hypertension, and then we got their blood pressure under control, we could still bill for hypertension." #34, Physician in obesity focused practice 15. "[Patients] are allowed a once a year a preventive visit and that's the one time you can deal with something like that [obesity]. So, you have to list the physical first, and then you can list out the fact that you gave 'em a BMI number, and talked to them about diet and exercise. So, the frustrating things is, is that you can't really say that you treat obesity. Nobody does. We don't get paid for that...maybe they ought to pay us for treating it." #52, Physician in standard primary care practice 16. "It's not as straightforward as they [Medicare] made it to be. Like I read the 40–60 pages of how to bill and things of that nature with Medicare back in the day. And it's not that straightforward because I would bill and they will come back saying, "Oh, it's denied because you don't have this code." So it's not 100% transparent in that way." #1, Physician in obesity focused practice 17. "We reward bad behavior, right. I mean I'm sitting in my office looking at the common area across from my door, and it's Friday, and people are bringing food to the office, and you can bet it's not a vegetable tray, right?" #55, Practice manager, hybrid primary care/obesity practice 18. "It is routine for us to admit you know patients into our ICUs just with obesity-related illness. You know, you go out to eat, you go to the mall, you go to Walmart—it's everywhere, and the hospital's no different. It is kind of normalized within some subcultures, within some families. It's self-propagating. I mean, goodness, I've got, you know, a family will come in everybody is over 400 pounds, and how am I gonna break this cycle?" #59, Physician in standard primary care practice 19. And that's the important thing is that they haven't given up, and you can have set backs, then you can have some yo-yoing and, you know, up and down, but obviously
Challenge #4—I am fighting an obesogenic American culture	
Theme 3: Despite the challenges, many clinicians find treating obesity rewarding and satisfying	

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Table 2. (continued)

Theme/challenge	Example quotation (interview number, role, and type of practice follow quotation.)
	what's the best success, when somebody does lose a lot of weight, when they turn around their sugar, when they turn around their blood pressure. You know, those are the tremendous victories that we don't get very often, but when you get them, it's wonderful and exciting... #40, Physician in standard primary care practice 20. Yeah. And it's been fun, you know. It puts some fun back into practice [laughing]. It's really good and people are so happy and thankful, and you know, it just gives so many people a new lease on life. #13, Physician in standard primary care practice 21. "You get to celebrate stuff with them ... and that gives you some of your job satisfaction back that's being sucked outta ya every day with this other stuff that's going on. Cause when you're seeing results, they're happy, you're happy, you're talking about things that really are impacting their life, and they're happy." #17, Physician in standard primary care practice 22. It's just so rewarding...she was the most bristly, porcupine-type patient. [I] worked with her and she lost 60 pounds, and then kind of lost track of her, and then on my desk was an invitation that in her church you could ask anybody on earth who's changed your life to come to church with you that one day. And that invitation showed up on my desk—to come to the church service with her as a thank you for the biggest person who's made the biggest change in her life, and you could have just blown me away with a feather. #79, Physician in standard primary care practice

There were two primary themes participants described regarding the challenges with payment and billing. First, the reimbursement amount for IBT for obesity is much less than for other services taking the same or less time; a 15-min individual visit coded G0447 is reimbursed \$26. Payment for a basic Evaluation & Management (E&M) code (99213) for equivalent time is typically reimbursed three to four times that amount. Clinicians quickly realized that they would lose money for each patient they saw if they only billed this code. However, many shared how the provision of weight management was financially feasible. As obesity is often comorbid with other conditions, some clinicians opted to use other professionals (e.g., RDs) to provide weight loss services (quotation 13), often using medical nutrition therapy (MNT) for other diagnoses. Other clinicians billed E&M codes for patients' comorbid

conditions and then primarily addressed obesity during the visit. Many specialized programs also collected patient out-of-pocket fees. Another billing challenge is that the IBT for obesity code has strict requirements for reimbursement that often conflict with ongoing management for weight. For example, one key complaint was that once a patient's BMI drops below 30 into the overweight but not obese range, the patient becomes ineligible for the IBT benefit. This was seen as conflicting with the recognition of obesity as a chronic disease, as reimbursement practices do not support continued obesity management after it is controlled (quotation 14). In addition, clinicians reported that reimbursement of preventive services in general is limited (quotation 15). Finally, respondents also reported that the process for billing and receiving reimbursement is difficult to understand (quotation 16).

Challenge #4—I am fighting an obesogenic American culture

Respondents uniformly reported that American culture and the current structure of the health care system work against successful treatment of obesity. They believe changing the trajectory of the obesity epidemic will require systematic change outside of medical practice. Because of the cultural overlay, they described patients with low motivation to change; or conversely, expecting rapid change and not following up after initial visits (quotation 17). They reported that patients struggle to sustain change due to several cultural factors, including easy access to highly palatable but nutritionally poor food and lifestyles that do not allow for meal planning or encourage healthy behaviors (quotation 18). They believe that patients lack the tools to fight all the societal influences running counter to a healthy lifestyle and that without special training and procedures, their clinicians and care teams cannot overcome these forces.

Theme 3: Despite the challenges, many clinicians find treating obesity rewarding and satisfying

Despite the multitude of challenges involved in treating obesity, we found a substantial group of clinicians (medical, nutritional, behavioral, and other) in primary care who find great satisfaction in helping patients with weight loss. This theme was prominent, explaining why some clinicians continue to work to address obesity with their patients. Often, respondents contrasted the satisfaction of treating obesity and comorbidities with the drudgery of seeing patient after patient with chronic disease when obesity is not addressed as a root cause (quotation 19). However, actively working with patients on weight loss goals and seeing progress can be rewarding and satisfying, in part from positive interaction with and success of patients and also from addressing the importance of prevention and health promotion (quotation 20). Finally, clinicians reported patient weight-loss success as immensely rewarding because it often leads to increased connection and improved relationships with patients (quotations 21 and 22).

DISCUSSION

The experience of providing weight management in primary care has a profound effect on clinician and care team commitment and motivation to treat obesity. Our three primary themes indicate that while many clinicians see obesity management as important and enjoy providing it, the challenges presented by this work lead many to abandon this type of care.

Some of the challenges we uncovered are practical in nature. One—funding—aligns with previous research that reimbursement for obesity-related services without another condition to bill under is low or nonexistent^{17–19}. Clinicians are already tasked with an enormous workload, as well as financial pressures to increase volume. When obesity treatment is not well reimbursed and is time consuming, it is not prioritized. While Medicare's IBT for obesity benefit is an important first step in the right direction, many respondents reported that they had discontinued billing for the IBT benefit due to the overwhelming hassles of trying to use it. Until policies support adequate compensation for obesity treatment in primary care, it will remain difficult to provide these services to patients in a high-quality manner.

Another practical barrier is lack of training during medical school and residency or as continuing medical education. As reported elsewhere,^{10–12} our findings also indicate that clinicians are challenged by the need for additional training. Although evidence-based treatments are available, many clinicians hesitate to use them as they perceive uncertainty about their long-term efficacy and safety. In addition, the association of obesity with “lifestyle choices” leads some to believe that obesity should not be medicalized with drugs or procedures such as surgery.

While the discouraging results in our study are similar to other findings reported in the literature²⁷, we were unable to find studies that describe the joy in helping patients with weight management. We found that clinicians and care teams who find ways to make helping patients with weight loss a routine part of their practice (i.e., finding other means of reimbursement or using a team approach) exhibited the most satisfaction. We were encouraged to find that these practices are thriving; they can serve as models for use by others. These findings corroborate a previous survey study that found that a sense of calling among clinicians was correlated with satisfaction in treating obesity and other challenging behavioral health issues. Specifically, 57% of physicians experienced “some” or “a lot of” satisfaction in treating obesity when they described ideals such as “the practice of medicine is a calling.”²⁸ In addition, the relationships that physicians described developing with patients around obesity management are important for maintaining satisfaction with practicing primary care medicine. Physicians who choose primary care do so because they value close patient relationships²⁹ and practicing physicians consistently rate patient relationships as the most satisfying part of their work³⁰. Our results indicate that while treating obesity is challenging, it can provide this satisfaction and reward for many clinicians.

Based on these findings, we make several recommendations that may improve the experience of clinicians and teams in providing obesity care. First, increased reimbursement for team-based obesity care (incorporating RDs and behavioral health clinicians) would increase patient access to effective care. Second, there is a need for improved clinician training in evidence-based weight loss treatment as well as implementation strategies that are feasible for primary care settings to use. Recent evidence supports the effectiveness of combining clinical training with curricula that are feasible to implement and effective in primary care settings,^{31, 32} such as combining obesity management training for clinicians with clear guidance on how to use an IBT-like curriculum with patients. Another option is obtaining certification in obesity medicine, through organizations such as the Obesity Medicine Association³³. These clinician- and patient-targeted interventions could make treating obesity easier, increasing the reach of weight management. Last, and perhaps hardest, truly addressing obesity requires societal and cultural changes.

Our findings are limited to those of the practices in this study, representing the lived experiences of primary care practices that provide and do not provide obesity services, but may not represent the experiences of all practices. In addition, these experiences are based on self-report and therefore not verified. The data were qualitative in nature as our purpose was to seek understanding to explore participants' experiences and identify points of guidance for future recommendations.

CONCLUSION

Clinicians who are interested in providing weight management can find encouragement that many clinicians and clinical team members truly enjoy helping patients manage their weight. These teams have found effective ways to implement obesity care into their practice and financially sustain this work. Our findings suggest that this is possible. However, there is progress to be made, including developing effective structures and systems to support work in this area and, ultimately, addressing our obesogenic culture. Despite the well-documented challenges, we found that clinicians universally recognize the importance of treating obesity as an important part of primary care practice.

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1007/s11606-020-06548-w>.

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Compliance with Ethical Standards:

MOST was approved by the Colorado Multiple Institutional Review Board (IRB) as well as the IRBs at Duke University and Michigan State University.

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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