

The Evolving Role of Registered Dietitian Nutritionists in Obesity Management with Medications and Lifestyle Interventions

Executive Summary

This report highlights the vital role of registered dietitian nutritionists (RDNs) in providing lifestyle interventions for adults who are prescribed obesity medications, including the FDA-approved incretin-based therapies. The audience for this brief report includes RDNs and other health care providers, policymakers, pharmaceutical manufacturers, and healthcare plan and insurance decision makers. A detailed scientific report on providing medical nutrition therapy (MNT) with obesity medications, specifically incretin-based therapies, is forthcoming.

Standalone lifestyle interventions delivered by RDNs have proven effective for obesity management, and early obesity medications were found to be more effective when combined with lifestyle interventions. Current research shows significant weight loss can be achieved, especially with the newer incretin-based therapies, including when combined with lifestyle interventions provided by RDNs. However, a comprehensive body of research on the role of lifestyle interventions with these medications does not currently exist.



RDNs provide evidence-based, personalized care to prevent and manage obesity-related health issues. Collaborating with other health care professionals, RDNs emphasize person-centered care, helping clients navigate medication choices, set realistic goals, and manage side effects. They also provide essential support in promoting healthy lifestyles, ensuring nutritional adequacy and maximizing maintenance of weight loss.

Advocacy for improvements in public and private payer coverage of MNT, obesity medications and obesity management is ongoing. Federal legislative efforts, such as the Treat and Reduce Obesity Act that seeks to expand access to comprehensive obesity management, including RDN services. RDNs and other healthcare providers, policymakers, pharmaceutical manufacturers, and healthcare plan and insurance decision makers should work together to provide individualized, equitable obesity management for all in need of these services.



Introduction

Since 2013, obesity has been acknowledged as a chronic disease,¹ and linked to various health conditions like atherosclerotic cardiovascular disease, type 2 diabetes mellitus (T2DM), and obstructive sleep apnea.² The Academy of Nutrition and Dietetics (Academy) recognizes obesity as a prevalent chronic illness and advocates for quality care for all through the Obesity Bill of Rights.³ Recent advancements in obesity management include medications that aid in achieving significant weight loss by effectively reducing appetite and hunger. In an early 2024 statement, the Academy emphasized the importance of RDNs in obesity management, stressing the need for evidence-based resources and a collaborative healthcare approach.⁴ This statement urges policymakers, health care providers, and the public to prioritize access to comprehensive obesity care by combining medical nutrition therapy (MNT) and other lifestyle interventions along with obesity medications to help people with overweight and obesity achieve improved health outcomes (**Figure 1**).

Figure 1. Excerpt from Academy of Nutrition and Dietetics Statement on Obesity Medications⁴

Incorporating nutrition and lifestyle interventions is imperative in the comprehensive management of obesity across the continuum of care. Individuals taking obesity medication must have access to evidence-based lifestyle interventions within medical nutrition therapy services delivered by registered dietitian nutritionists to optimize health outcomes and to address the multifaceted aspects of obesity.

Currently, there is discussion about the often-used term “anti-obesity medications.” For some people, this term evokes stigma. Alternative terms, like “incretin-based therapies” or the term nutrient-stimulated hormone-based therapies (NuSHs), are being proposed and used for more inclusive and person-centered language. This brief report refers to these newer obesity medications as incretin-based therapies. **The main goal of this brief report is to explain the crucial role of lifestyle interventions, including medical nutrition therapy (MNT) provided by RDNs, for adults (≥18 years) who are prescribed an incretin-based therapy and/or other obesity medications.** The target audience of this report includes RDNs and other health care providers, policymakers, pharmaceutical manufacturers, and healthcare plan and insurance decision makers. A full scientific report describing evidence and expert guidance on providing MNT with incretin-based therapies is forthcoming.

Brief Background on Incretin-based Therapies as a Category of Obesity Medications

The pursuit of safe and effective obesity medications has a long history,⁵ with several medications gaining approval from the U.S. Food and Drug Administration (FDA) over the past few decades, such as orlistat, naltrexone/bupropion, and phentermine/topiramate ER. Medication development

in this area has been robust.^{3,4} Currently FDA approved incretin-based therapies and key details about these medications is described in the **Appendix**.

There is a growing understanding of the role incretin hormones play in obesity. Like the hormone insulin, these hormones are crucial regulators of metabolism and have a more significant impact on glucose and lipid levels, as well as body weight, than previously recognized. Incretin-based therapies, such as Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) result in suppression of appetite and increased release of insulin by the pancreas when glucose levels rise after eating. Unlike previously FDA approved obesity medications, the newer incretin-based therapies, such as semaglutide and tirzepatide, result in weight reductions of 15-20%, surpassing the 10% or lower seen with earlier therapeutic agents.⁶ Incretin-based therapies, particularly the newer medications, not only enhance weight loss but also offer other health benefits, such as improved glucose management,⁷ cardiovascular health,⁸ and management of other obesity-related conditions like chronic renal disease⁹ and obstructive sleep apnea.¹⁰ While people with T2DM may experience slightly less weight loss, they still experience significant health benefits.¹¹ Ongoing research promises further insights into the broader health implications of these medications and those under development.

Evidence in Support of Lifestyle Interventions for Obesity Management

Research that documents the use of incretin-based therapy delivered in tandem with lifestyle interventions is currently scant. However, there is robust evidence supporting efficacy of lifestyle interventions in adults with obesity, including those delivered by RDNs.^{12,13} In adults with obesity, lifestyle interventions provided by RDNs can reduce body mass index (BMI), waist circumference, blood pressure, and glucose in adults with T2DM, and improves quality of life.¹² Lifestyle interventions delivered by an RDN also can improve outcomes for obesity-related conditions such as dyslipidemia,¹⁴ prediabetes,¹⁵ T2DM,^{16,17} and hypertension.¹⁸ Past obesity medications showed enhanced potential for effectiveness when combined with intensive behavior therapy,^{19,20} and current research indicates substantial weight loss with incretin-based therapies alone or in combination with lifestyle interventions.^{6,21-28} Important outcomes such as quality of life, nutrient balance, and management of medication side effects currently lack thorough examination.

RDNs Should Deliver Lifestyle Interventions for Optimal Obesity Management

RDNs can and should play a significant role in providing lifestyle interventions for people with obesity, offering comprehensive care throughout all stages of management including long-term weight loss management.²⁹⁻³¹ Global health organizations recognize the importance of RDN-provided interventions as a cornerstone of obesity treatment.^{24,29,32-34} RDNs provide MNT, which is grounded in evidence-based practices aimed at preventing, delaying, or managing various health conditions associated with obesity.³⁵ RDNs have extensive education and training in nutrition sciences and counseling strategies. Some RDNs may acquire specialized certifications like Board Certified Specialist in Obesity and Weight Management (CSOWM)³⁶ or Certified Diabetes Care and Education Specialist (CDCES).³⁷ RDNs collaborate with interprofessional health care teams to deliver comprehensive obesity management within their respective scopes of practice.^{29,31}

Notably, while RDNs do not prescribe medications, it can be within their scope of practice to take on roles to support the prescribed treatment plan. These include guiding clients towards evidence-based decisions,

fostering healthier lifestyles, and assisting in the prevention or management of adverse side effects from medications, and more.

RDNs review dosage and titration with clients and can advocate for dose adjustments with prescribers if indicated. RDNs can also advise clients to consider safety of obesity medications, including for counterfeit versions and compounded formulas.³⁸ Injectable medications are new to most clients. For injectable medications RDNs can review administration, storage, and disposal of sharp objects. As interventions progress, RDNs can monitor clients for mood changes and body composition alterations. RDNs can also assist clients in ensuring comprehensive care and support. In times of medication shortages, RDNs can play a pivotal role in helping clients sustain healthy habits, emphasizing nutrition's role in managing obesity effectively. Ultimately, RDNs serve as essential partners in the holistic management of obesity, offering expertise, support, and personalized guidance to individuals on their weight loss journey towards improved health and well-being.

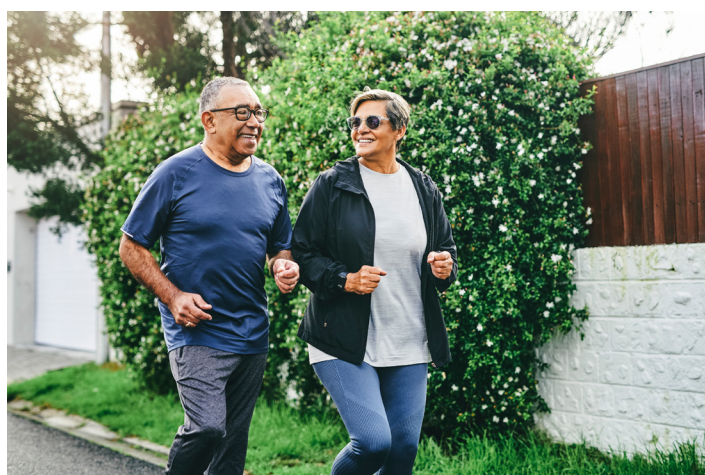
Providing Lifestyle Interventions in Conjunction with Incretin-based Therapies

A full scientific report on providing lifestyle interventions with incretin-based therapies is forthcoming. The following provides an overview of the role of RDNs in delivering lifestyle interventions for adults with overweight and obesity.



RDNs collaborate with clients using shared decision-making to develop personalized nutrition plans which consider the diverse needs and circumstances of each individual.²⁹ RDNs actively address weight bias and stigma,²⁹ help clients navigate obesity medication choices, foster a supportive environment to ensure alignment with individual health goals, monitor metabolic indicators, assess for indicators of malnutrition and more. RDNs can and should continue to enhance their counseling skills from proficient to expert to increase the likelihood that the client will achieve their desired benefits of therapies.^{30,33}

With the use of the newer incretin-based therapies and their impact on appetite and satiety, the focus of lifestyle interventions delivered by RDNs has shifted. Rather than placing the focus on achieving calorie reduction, nutrition counseling with these newer medications should instead focus on nutrient quality, adequate nutrient intake, regular food intake, sufficient protein consumption to minimize loss of lean body mass and adequate fluid consumption. In addition, through the course of obesity management, clients and RDNs should focus on developing healthy and sustainable eating habits and patterns to minimize weight regain with or without the continued use of incretin-based therapies.^{24,31} RDNs should screen and monitor clients for factors that may impact the efficacy, feasibility and appropriateness of obesity medications, including other prescribed medications that can impact weight or risk of hypoglycemia, eating disorders and disordered eating and gastrointestinal disorders and side effects.^{33,39} Managing cravings, setting realistic expectations, and promoting physical activity for health and well-being are crucial.⁴⁰



Weight Loss Maintenance and Long-Term Use of Incretin-based Therapies

Maintenance of weight loss is challenging for a broad array of reasons. While research has demonstrated the significant impact on weight loss of incretin-based therapies along with other obesity-related health conditions, the length of time a person can and should stay on an incretin-based therapy and the optimal dose is under further exploration and guidance will evolve.

It is reported that approximately 50% of individuals who are prescribed an incretin-based therapy stop taking it within a year of initiation.^{41,42} Reasons include gastrointestinal side effects, cost and availability of medication and challenges using an injectable medication.⁴³ Other obesity medications, such as phentermine/topiramate or naltrexone/bupropion, may be utilized in addition to or in place of incretin-based therapies to aid in weight loss maintenance. The limited available evidence to date shows that the discontinuation of the incretin-based therapies can lead to weight returning to baseline.⁴⁴ Wadden et al. suggest transitioning off medications with a two to three-month behavioral program to maintain weight loss.²⁴ Gradual reduction of an incretin-based therapy may be able to mitigate weight regain. Each person who has achieved weight loss should work with their providers to collaboratively develop a weight loss maintenance management plan that may or may not include an incretin-based therapy and/or other obesity medication. This personalized approach can ensure effective obesity management and overall health.

Coverage of Newer Incretin-based Therapies and MNT for Obesity Treatment

Despite FDA approval of current and future incretin-based therapies for obesity management, continued emphasis should be placed on the importance of ongoing concurrent lifestyle interventions. To date, access to nutrition related lifestyle interventions, such as MNT and intensive behavioral therapy (IBT), remain limited among private and public payers.

It is important for health care providers, including RDNs, to understand and navigate the complex healthcare environment, especially regarding coverage for obesity medications and MNT. For example, over half of Americans obtain their health insurance through their employers,⁴⁵ and employers' decisions are influenced by

their medical carriers and health consultants. Covering incretin-based medications is complex for employers, balancing empathy with economics. These medications, which are now a major driver of non-specialty pharmacy trends, are high in cost, even after discounts and rebates. Historically, obesity medications were often excluded from coverage, but now 42% of large employers cover them, usually with prior authorization requirements.⁴⁶

Addressing obesity through medications and MNT may improve public health outcomes and workforce productivity. Health plan and insurance decision makers should include access to RDNs for MNT, and obesity medications as part of their obesity management strategies. Many employers are partnering with third-party vendors or pharmacy benefit managers, which may or may not include RDN access, in their programs.

While most public and private payers cover MNT for diabetes, fewer cover it for obesity and preventive care. Healthcare plan and insurance decision makers often overlook the minimal cost of MNT coverage in the broader context of healthcare expenses. The Academy continues to advocate for expansion of MNT through federal and state legislation and working with third-party payers.

Policies for Improving Access to Obesity Treatment

For adults who are prescribed obesity medications, access to RDNs providing MNT can minimize side effects and enhance the medications' effectiveness. MNT is a low-cost, flexible obesity treatment that can be tailored to different settings and delivery methods. Insufficient coverage for sustainable, comprehensive obesity care results in poorer health outcomes and increased health inequities.

The Academy urges policymakers to support comprehensive, evidence-based obesity management, including services delivered by RDNs. The current lack of coverage for these services forces adults with obesity to either avoid nutrition care altogether or opt for higher-cost options that may not have the necessary support to optimize interventions. Currently, two pieces of legislation aim to improve access to comprehensive obesity care. The bipartisan Treat and Reduce Obesity Act (TROA) seeks to expand Medicare coverage for obesity medications and broaden coverage of other health care providers, including RDNs for IBT. The Medical Nutrition Therapy Act, which is also bipartisan, advocates for increased coverage of MNT by RDNs for conditions like obesity, prediabetes, hypertension, dyslipidemia, and cardiovascular disease. Expanded MNT coverage is necessary for all clients with obesity, including those on Medicare, prescribed obesity medications, or undergoing metabolic and bariatric surgery.



Conclusions and Call to Action

New obesity medications, including incretin-based therapies, can play a crucial role in improving outcomes for adults with overweight and obesity. Lifestyle interventions, such as IBT and MNT provided by and RDN, should be provided in tandem with incretin-based therapies. This approach ensures and optimizes medication adherence, diet quality and nutrient adequacy, and prevention and management of medication side effects.

Advocacy for improved coverage of lifestyle interventions and MNT for obesity management is ongoing, with an aim of improving health outcomes and equity in obesity care. Key actions needed to improve access to quality and effective obesity care are described in **Figure 2**. RDNs and other health care providers, policymakers, pharmaceutical manufacturers, and healthcare plan and insurance decision makers can work together to provide individualized, equitable obesity management strategies.

Figure 2. Calls to Action for Partners in Improving Efficacy of Client-Centered Obesity Care



Support laws that lower barriers to proper obesity care, like the Medical Nutrition Therapy Act and the Treat and Reduce Obesity Act.



Insurers and employers should provide comprehensive obesity management programs to improve health and productivity, including access to obesity medications and RDN-led lifestyle interventions.



RDNs should collaborate with national obesity organizations, policymakers, researchers, and health care teams to ensure patients receive personalized lifestyle interventions at all stages of obesity treatment.



Support and participate in research on the effects of obesity medications on body composition and nutrient status, as well as strategies to maintain weight loss after reducing or stopping these medications.

RDN= Registered Dietitian Nutritionist

Appendix. Currently FDA-Approved Incretin-Based Therapies*

Generic Name	Brand Name	Injectable (subQ)/Oral	Initial FDA-approval date, indication(s) as of 5/2024 [^]	Abbreviations of Key Study Series Name(s) ⁺	Dose Range/Frequency	Device Description (Medication comes prefilled in pens)
Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RA)						
exenatide (immediate release)	Byetta	Injectable	2005, 10 years old and older, type 2 diabetes, adjunct to diet and exercise [#] , glycemic control	EXSCEL	5, 10 mcg twice/day, take within 60 min before eating	Pen (uses disposable pen needles)
exenatide XR	Bydureon	Injectable	2012, 10 years old and older, type 2 diabetes, adjunct to diet and exercise [#] , glycemic control	DURATION	2 mg weekly	Pen injector-Bydureon BCise (needle is hidden)
liraglutide	Victoza	Injectable	2010, 10 years old and older, type 2 diabetes, adjunct to diet and exercise [#] , glycemic control; indication added 2017: reduces risk major adverse CV events, and established CVD	LEADER	0.6, 1.2, 1.8 mg, daily (doesn't have to be taken before meals)	Pen (uses disposable pen needles)
liraglutide	Saxenda	Injectable	2014, Adults with BMI ≥ 30 or ≥ 27 if weight-related medical issues Pediatric: 12 years old and older, initial weight > 60 kg (132 lbs)	SCALE	0.6 – 3.0 mg maximum dose, dosing is once daily	Pen (uses disposable pen needles)
dulaglutide	Trulicity	Injectable	2014, Adults, type 2 diabetes, adjunct to diet and exercise [#] , glycemic control, 2020: reduces risk of major adverse CV events, and established CVD, or multiple risk factors	REWIND	0.75, 1.5, 3.0, 4.5 mg once weekly	Pen injector (needle is contained in pen and hidden)
semaglutide	Ozempic	Injectable	2017, Adults, type 2 diabetes, adjunct to diet and exercise [#] , glycemic control; 2020: reduces risk of major adverse CV events, and established CVD	SUSTAIN	0.25, 0.5, 1.0, 2.0 mg once weekly	Pen (uses disposable pen needles)
semaglutide	Rybelsus	Oral	Adults, T2D, adjunct to diet and exercise [#] , glycemic control	PIONEER	3, 7, 14 mg daily in the morning. Take on empty stomach alone with 4 oz water, at least 30 min before eating and drinking	N/A (an oral medication)
semaglutide	Wegovy	Injectable	2021, Adults: BMI ≥ 30 or ≥ 27 if at least one weight-related medical issues. Pediatric: 12 years old and older, initial BMI 95th percentile, age, sex; 2024: reduces risk of major adverse CV events, and established CVD	STEP, SELECT	0.25 mg, 0.5 mg, 1 mc, 1.7 mg, 2.4 mg maintenance dose, once weekly	Pen (needle is contained in pen and hidden)
GLP-1 Receptor Agonists with Glucose-dependent Insulinotropic Polypeptide (GIP)						
tirzepatide	Mounjaro	Injectable	2022, 18 years old and older with type 2 diabetes	SURPASS	2.5, 5.0, 7.5, 10, 12.5, 15 mg, once weekly	Pen (needle is contained in pen and hidden)
tirzepatide	Zepbound	Injectable	2023, 18 years old and older, BMI ≥ 30 or ≥ 27 if at least one weight-related medical issues	SURMOUNT	2.5, 5.0, 7.5, 10, 12.5, 15 mg, once weekly	Pen (needle is contained in pen and hidden)

*Listed chronologically as they were FDA-approved.

[^]Details on FDA approval indication(s) as of 5/2024. Medications are FDA-approved initially and on-label for specified uses based on submitted research by the applicant, such as a pharmaceutical company. With additional research outcomes submitted, the FDA can approve additional indications for the use of a medication that are then integrated into the package insert (PI). These are FDA-approved on-label uses. Prescribers can use FDA-approved medications off-label. This means medication is being used for an unapproved indication or in an unapproved age group, or dosage. According to the FDA, providers may prescribe a medication off-label if they make the clinical decision that the medication is medically appropriate. (Ref: FDA. <https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label>). In addition, FDA can issue new label warnings for FDA-approved medications at any time. FDA also maintains a drug shortage list. Currently, several of the incretin-based therapies are on this list. (Ref: <https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>.)

[#]The terms “diet and exercise” have been used by the FDA for medication approvals for decades and are thus the terms they require in pharmaceutical advertising.

⁺These acronyms for studies represent some, but not all, of the series of studies conducted to date in the research and development for each medication to support FDA initial approval and additional indications. Additional studies in some of these series are ongoing. Some of these studies are also used for regulatory approval by other global government regulatory agencies.

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Hope Warshaw, MMSc, RD, CDCES, BC-ADM, FADCES, is the owner of Hope Warshaw Associates, LLC, a diabetes- and nutrition-focused consultancy based in Asheville, North Carolina. She has spent her career, spanning over forty-five years, specializing in diabetes care and weight management. Warshaw has written award-winning consumer books and hundreds of consumer-facing articles. For years she has developed health care provider-focused content that translates science into practice. She has served in leadership roles nationally including positions with the Academy's Diabetes Dietetic Practice Group, including chair. She was a founding member of the Weight Management Dietetic Practice Group. After serving the Association of Diabetes Care and Education Specialists (ADCES) in numerous leadership positions, Warshaw was president in 2016. Warshaw has served on the Academy's Foundation board since 2018, as chair during 2022–2023 and past-chair during 2023-2024. She was recently elected to serve on the Academy's Nominating Committee. Recently, Warshaw has been working with the Academy Foundation to spearhead support for and development of a webinar series on obesity medications specifically for RDNs.

Colleen Dawkins

Colleen Dawkins, MSN, ARNP, FNP-C, MS, RDN, CSOWM, is a nurse practitioner in private practice at Big Sky Medical Wellness. She is board-certified in family medicine, a Registered Dietitian Nutritionist, and a Certified Specialist in Obesity and Weight Management. Currently, Colleen serves as secretary for the Washington Obesity Society, vice chair for the Commission on Dietetic Registration's Obesity Certificate of Training program advisory board, member of the Obesity Medicine Association's algorithm committee, associate editor for *Obesity Pillars Journal*, member of an international research collaboration, item writer for the American Academy of Nurse Practitioners Board Certification examination, and is currently a doctoral student at the University of Southern Mississippi.

Alison Evert

Alison Evert, MS, RDN, CDCES, FADCES, is a registered dietitian nutritionist and diabetes educator. Most recently she managed a team of registered dietitian nutritionists/certified diabetes care and education specialists at the University of Washington - Medicine Primary Care Network. She writes and presents frequently about the role of nutrition therapy in diabetes for health care professionals and people with diabetes. In 2023, Alison was selected to serve a 4-year term on the Board of Directors for the Certification Board for Diabetes Care and Education Specialists. Alison served as the co-chair of the *American Diabetes Association's 2019 Consensus Report: Nutrition Therapy for Adults with Diabetes and Prediabetes*. She is a long-time member of the Academy of Nutrition and Dietetics and has served as a chair of the Diabetes Dietetic Practice Group. She was awarded the Academy's Medallion Award, the Diabetes Dietetic Practice Group's Distinguished Service Award, and the state of Washington's Outstanding Dietitian Award. Alison holds a master's degree in nutrition from Rosalind Franklin University of Medicine and Science.

Linda Gigliotti

Linda Gigliotti, MS, RDN, CDCES, FAND, is a registered dietitian nutritionist with extensive experience in the clinical practice of adult medical weight management, multidisciplinary obesity treatment teams, and worksite wellness. She is the former Director of the Weight Management Program at the University of California, Irvine. Additional professional experiences include nutritional support, academic appointments, and community education. Colleagues have recognized her leadership in program development, particularly in the areas of medically supervised weight management and worksite wellness weight management settings. She has held numerous roles with the Academy of Nutrition and Dietetics and the Commission on Dietetic Registration and was engaged in the development of the interprofessional Certified Specialist in Obesity and Weight Management (CSOWM) credential. She is co-editor of the *Health Professionals Guide to Treatment of Overweight and Obesity* published by the Academy in 2024. In 2021 she was awarded the Medallion Award by the Academy of Nutrition and Dietetics. She is also a recipient of the Excellence in Weight Management Practice Award by the Weight Management Dietetics Practice Group in 2017 and the California Outstanding Dietitian of the Year Award in 2018. Linda holds a master's degree in nutrition education from the University of Delaware.

Julie Schwartz

Julie Schwartz, MS, RDN, CSOWM, LD, NBC-HWC, ACSM-EP, has over 25 years of experience guiding people to a healthy lifestyle. She currently works at Intellihealth Inc. as an obesity medicine registered dietitian providing virtual lifestyle interventions, wellness coaching and program development as part of a collaborative medical team specializing in obesity medicine including tier one and incretin-based therapies. Julie has served in numerous professional leadership roles in the WM DPG, the Academy of Nutrition and Dietetics and the membership services task force for the CV-Well DPG. Julie has co-authored numerous publications including the *Physical Activity Toolkit* for Registered Dietitians: Utilizing the Resources of Exercise is Medicine®. She is the primary author of three of four modules of Certificate of Training: Health & Wellness Coaching for the Nutrition Professional. She is a key contributor in the development of the interdisciplinary Certified Specialist in Obesity and Weight Management (CSOWM) credential and serves as a subject matter expert on the interdisciplinary committee continuing to advance the credential. Julie was awarded the Academy's Medallion Award in 2022 and received the Excellence in Weight Management Practice Award from the Weight Management Dietetics Practice Group in 2021.

Caroline Susie

Regularly featured on news outlets, Caroline Susie, RDN, LD, is an award-winning dietitian, national spokesperson for the Academy of Nutrition and Dietetics and a consultant within Mercer's MercerWELL specialty practice where she leads Mercer's Advocacy vertical. Working alongside Health and Benefit leads, she advises clients of all sizes on how to identify health improvement opportunities that deliver results. Caroline is a University of Oklahoma graduate with 20 years of experience as a registered and licensed dietitian.

Robert Kushner

Robert Kushner, MD, MS, is Professor of Medicine and Medicine Education at Northwestern University Feinberg School of Medicine, and Director of the Center for Lifestyle Medicine in Chicago, IL, USA. Dr. Kushner is past-President of The Obesity Society (TOS), the American Society for Parenteral and Enteral Nutrition (ASPEN), the American Board of Physician Nutrition Specialists (ABPNS), and a founder and first Chair of the American Board of Obesity Medicine (ABOM). Dr. Kushner has authored over 250 original articles, reviews, books and book chapters covering medical nutrition, medical nutrition education, and obesity, and is an internationally recognized expert on the care of patients living with obesity. He is author/editor of multiple books including *Nutrition and Bariatric Surgery* (CRC Press, 2015), *Lifestyle Medicine: A Manual for Clinical Practice* (Springer, 2016), *Obesity Medicine, Medical Clinics of North America* (Elsevier, 2018), *Creating a Lifestyle Medicine Center* (Springer, 2020), and *Primary Care: Evaluation and Management of Obesity* (Wolter Kluwer, 2022). His latest popular book is *Six Factors to Fit: Weight Loss that Works for You!* (Eat Right Press, 2020). Dr. Kushner's research interests include medical and obesity education, and lifestyle and pharmacological approaches to obesity.

Savitha Subramanian

Savitha Subramanian, MBBS, is a Professor of Medicine at the University of Washington (UW) Department of Medicine, Division of Metabolism, Endocrinology and Nutrition and the Medical Director of the UW Lipid Clinic. She trained in endocrinology at Washington University in St. Louis and a lipid research fellowship at the University of Washington in Seattle, Washington. She has a special interest in caring for individuals with genetic lipid disorders, partial lipodystrophy and complex diabetes. She developed protocols for improved diabetes management and diabetes technology use in UW Medicine primary care and is an active contributor to the UW Diabetes and Cardiometabolic Project ECHO (Extension for Community Healthcare Outcomes) program that enhances cardiometabolic health in under-served communities. Dr. Subramanian has served on the Lipid Management Guideline task force of The Endocrine Society and is a current member of the American Board of Internal Medicine's Endocrinology Examination Approval Committee. She is involved in many teaching activities for trainees and clinicians in practice and chairs the Primary Care CME courses in Diabetes and Endocrinology for the University of Washington. She works closely with medical students, residents, Endocrine and Cardiology fellows to nurture future cardiometabolic specialists. In 2022, she received the UW CARES award in recognition of exemplary patient care.

Deepa Handu

Deepa Handu, PhD, RDN, serves as a senior scientific director for the Academy of Nutrition and Dietetics Evidence Analysis Library. In her position at the Academy, she has led the development of several systematic reviews and clinical practice guidelines, driving advancements in evidence-based methodologies. Her extensive portfolio of research publications underscores her dedication to generating and synthesizing evidence to inform crucial clinical practices and position statements. Dr. Handu's research also focuses on conducting methodological studies to improve methods for evidence synthesis and guideline development in nutrition research.

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Mary Rozga

Mary Rozga, PhD, RDN, is a nutrition researcher at the Academy of Nutrition and Dietetics Evidence Analysis Center. Dr. Rozga earned her PhD in Human Nutrition and completed her dietetic internship at Michigan State University. Currently, she works as a systematic review, meta-analysis, and guideline methodologist. In this role, she collaborates with expert practitioners, researchers, and other implementation partners on a wide variety of nutrition topics to create evidence-based resources in the field of nutrition. In addition to leading several scoping and systematic reviews, evidence-based practice guidelines and organization position papers, Dr. Rozga has worked to evolve the methods for translating nutrition research into practice. Dr. Rozga is interested in determining best practices for applying gold-standard methods, such as the GRADE method, to nutrition evidence and practice. She has published primary and secondary research in several peer-reviewed journals and has presented research at state, national, and international scientific meetings.