

Webinar Three · Fireside Chat

Building the Modern Obesity Care Team

The Business and Clinical Case for RDN Integration

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Moderator: **Melissa Mitri, MS, RDN**

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Today's Conversation

A moderated fireside chat with two practitioners, three segments and nine takeaways.



Leslie Golden, MD, MPH, DABOM, FOMA
Physician Perspective

The economics behind a practice: what owners actually evaluate, and where nutrition care creates capacity.



Steph Wagner, MS, RDN, CSOWM
RDN Perspective

Translating nutrition expertise into value propositions that land with clinicians and decision-makers.



Melissa Mitri, MS, RDN
Moderator

Weight loss expert and nutrition communicator. Will keep each segment on time and brings us back to the takeaways.



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Disclosures

Leslie Golden, MD, MPH

Dr. Golden serves as a paid consultant for Boehringer Ingelheim, Novo Nordisk, Eli Lilly, Currax, Echosens, Viking Therapeutics, and Kailera Therapeutics; participates in speakers bureaus for Novo Nordisk, Eli Lilly, and Currax; serves as a physician spokesperson for Boehringer Ingelheim; and serves as a key opinion leader for Seca. She also holds nonfinancial leadership roles with the Obesity Action Coalition, Obesity Medicine Association, and Wisconsin Obesity Society. She is the owner of Weight In Gold Wellness, SC.

Steph Wagner, MS, RDN, CSOWM

Steph is the owner of Food Coach Me, LLC, DBA Bariatric Food Coach; Director of Nutrition for PsyMed Health; and a SunRise Nutrition Advisory Board member. She receives affiliate income from Celebrate Vitamins and ProCare Health and serves as the Policy and Advocacy Leader for the Academy's Weight Management DPG.

Melissa Mitri, MS, RDN · Moderator

Melissa is the owner of Melissa Mitri Nutrition and receives compensation for content creation and sponsorships from companies in the food, nutrition, supplement, and health industries. She is also the Newsletter Editor for the Academy's Weight Management DPG.

This session discusses obesity pharmacotherapy in the context of team-based care.



Learning Objectives

By the end of this session, participants will be able to:

- 1

Identify three high-value problems RDNs can solve

in medication-centered obesity care: adequacy and safety, complexity and transitions, and lived experience.
- 2

Translate RDN expertise into decision-maker language

across four currencies: clinical, operational, patient, and business outcomes.
- 3

Select practical models and workflows

that make RDN integration or referral easier for a practice to say yes to.



How the Next 90 Minutes Work

Three segments. Three points each. Three takeaways each. Then your questions.

TIME	SEGMENT	LEADS	MINUTES
1:00	Welcome, objectives, and the case	Melissa	10
1:10	One: The problems RDNs are trained to solve	Steph leads · Leslie responds	20
1:30	Two: Translating expertise into value	Leslie leads · Steph translates	20
1:50	Three: Making integration easy to say yes to	Leslie leads · Steph examples	20
2:10	Review of all nine takeaways	Melissa	5
2:15	Questions & conversation	All	15

Drop your questions in the Q&A box as we go. We will pull them into the conversation, not just save them for the end.



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The Case: Is There Still a Place for Me?

Our case is not a patient. It is a dietitian.

“

If medication is working, why do patients also need nutrition care?

Asked by a practice leader, in a real conversation many RDNs are having right now

The Situation

An RDN in an organization offering GLP-1–based obesity treatment is seeing **fewer referrals** than a year ago.

The Real Problem

She knows the work matters. What she does not have is a clear way to name **the problems she solves, the outcomes she creates, and a model that would work** for this practice.

Everything we discuss today comes back to helping her answer that question.



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Three Questions We Keep Coming Back To

Each question is one segment of today's conversation.

Segment One

01

What problems exist in obesity care today that RDNs are **uniquely trained to solve?**

The role is changing, not disappearing.

Segment Two

02

How do we communicate those problems, and our solutions, in **language physicians and practice leaders understand?**

From describing services to describing outcomes.

Segment Three

03

What makes it **feasible and compelling** for a practice to hire, integrate, or refer to an RDN?

There is no single right model.



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Segment One · 20 minutes

New Problems RDNs Are Trained to Solve

Medication-centered care changed patient needs. It did not eliminate nutrition needs.

Steph leads · Leslie adds the physician view

Central message: **the RDN role is changing, not disappearing.**



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1 | Three Problems Modern Treatment Creates

Not a list of everything an RDN does, just the problems that only exist because treatment works.

01

Adequacy and Safety

Appetite suppression is not the same as adequate nutrition. Protein, fiber, hydration and micronutrient intake, GI symptoms, lean mass and physical function all need active management.

02

Complexity and Transitions

Needs change at initiation, titration, maintenance, interruption and discontinuation, and change again alongside diabetes, MASLD, CKD or prior bariatric surgery.

03

Lived Experience

Translating a treatment plan into sustainable, flexible eating that preserves joy, culture, connection and trust, and holds up when the medication stops.

Every one of these problems got *bigger*, not smaller, when the medications started working.



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The Trials Never Studied Medication Alone

In the pivotal trials, **both arms** received structured lifestyle and nutrition counseling.

STEP 1 · Semaglutide 2.4 mg

“Participants received individual counseling sessions every 4 weeks to help them adhere to a reduced-calorie diet (500-kcal deficit per day...) and increased physical activity (with 150 minutes per week... encouraged).”

Wilding JPH, et al. N Engl J Med. 2021;384(11):989–1002.

SURMOUNT-1 · Tirzepatide

“Lifestyle intervention included regular lifestyle counseling sessions, **delivered by a dietitian** or a qualified health care professional... a deficit of 500 calories per day, and at least 150 minutes of physical activity per week.”

Jastreboff AM, et al. N Engl J Med. 2022;387(3):205–216.

74.2%

of semaglutide participants had a GI disorder (vs 47.9% placebo): nausea 44.2%, constipation 23.4%.

11.6 pts

of lost weight regained one year after semaglutide withdrawal, roughly two-thirds of the loss.

1.2–1.5

g/kg/day protein advised during GLP-1 therapy to help protect muscle and bone, with strength training.

GI and regain data: STEP 1 (NEJM 2021) and STEP 1 extension, Wilding JPH, et al. Diabetes Obes Metab. 2022. Protein guidance: joint advisory, Am J Clin Nutr. 2025.



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Segment 1 | Three Takeaways

Takeaways 1–3

1

Effective medication raises the stakes for nutrition assessment.

It does not remove the need. Reduced intake makes adequacy harder to achieve, and three-quarters of patients experience GI symptoms that shape what they can actually eat.

2

Weight change is one outcome, not proof of nutrition adequacy or function.

A falling number on the scale says nothing about protein intake, micronutrient status, lean mass, physical function, or a workable relationship with food.

3

RDN value spans the whole continuum, especially when needs change.

Initiation, titration, maintenance, interruption, discontinuation. Two-thirds of lost weight returns within a year of stopping; the transition is the clinical event.



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Segment Two · 20 minutes

Translate Expertise into Decision-Maker Language

Stop describing services. Start describing problems solved.

Leslie leads · Steph translates into RD actions

"I provide nutrition counseling" is a service. **Decision-makers buy solved problems.**



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2 | Four Currencies of Value

Different stakeholders pay attention to different currencies. Name the one your listener owns.

Clinical

Speaks to physicians

- Nutritional adequacy protected
- GI symptoms managed so patients stay on therapy
- Lean mass and function preserved
- Comorbidities co-managed

Operational

Speaks to administrators

- Physician visit time protected
- Titration questions handled outside the MD slot
- Continuity between visits
- Fewer repeat calls

Patient

Speaks to everyone

- Understands the plan
- Confidence and self-efficacy
- Adherence and follow-through
- Experience and trust

Business

Speaks to owners

- Retention across a chronic condition
- Program differentiation
- Quality metrics
- Billable capacity created

The Move

Instead of this

"I provide medical nutrition therapy and behavioral counseling."

Say this

"I keep your titrating patients eating enough to stay on therapy, without using your visit slots."



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The Evidence and the Payment Reality

Know the guideline that backs you, and know exactly how the visit gets paid for.

What the Guideline Says

MNT provided by RDNs is recommended to improve cardiometabolic, quality-of-life, and weight outcomes.

Academy Evidence-Based Practice Guideline, built on a systematic review of 70 randomized controlled trials.

The Dose That Works

- At least **5 interactive sessions**
- Delivered over **at least 1 year**
- Follow-up **every 3 months** after completion
- Across primary care, community and workplace settings

Morgan-Bathke M, et al. J Acad Nutr Diet. 2023;123(3):520–545.e10. Cost-effectiveness evidence graded low certainty.

How It Actually Gets Paid

Medicare MNT benefit

Covered for **diabetes and renal disease only**: CPT 97802 / 97803 / 97804. Three hours in year one, two hours annually thereafter.

Obesity alone is not a covered MNT diagnosis.

Intensive Behavioral Therapy

For BMI ≥ 30, **HCPCS G0447**, up to 22 visits per year. RDNs may deliver the service, but the supervising physician bills it, which is precisely why this is a **practice conversation, not a solo one**.

CMS National Coverage Determination for MNT; Medicare IBT for obesity guidance. Commercial coverage varies, so verify locally.



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Segment 2 | Three Takeaways

Takeaways 4–6

4

Start with the stakeholder’s problem, not a list of RDN services.

Lead with a pain point they already own and are already paying for. If they don’t recognize the problem, they will not fund the solution.

5

Describe the outcome created, in the currency your listener owns.

Clinical, operational, patient, or business. A physician and a practice administrator are not asking the same question, and should not hear the same sentence.

6

Make it measurable, and know how it gets paid.

Pair the story with two to four credible measures. Walk in knowing that obesity alone is not a covered MNT diagnosis for all plans, and that IBT is billed by the physician.



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Segment Three · 20 minutes

Make Integration Easy to Say Yes To

Not “what makes an RDN worth hiring,” but what makes it feasible for a practice to say yes.

Leslie leads · Steph gives working examples

There is **no single right model**; fit it to volume, workflow, economics, and patient need.



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3 | Five Models and What Each Requires

Match the model to the practice’s real demand, workflow and economics, not to your preference.

MODEL	FITS WHEN	PRACTICE MUST PROVIDE	MAIN FRICTION
Embedded	High, steady referral volume in one location	Salary, space, EHR access, schedule template	Fixed cost before volume is proven
Contracted	Demand exists but is not yet full-time	Sessions or days purchased, defined scope	Contract terms, supervision and billing clarity
Referral	Practice will not add headcount	A referral pathway and a named person	Referral dies if the loop never closes
Telehealth	Access, geography or no available space	Platform, consent, licensure check	State licensure and payer policy vary
Shared / external	Several small practices, none can staff alone	Shared agreement, common intake	Coordination across sites and records

Telehealth and community settings are explicitly supported delivery routes, not lesser versions of care.



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The Referral Friction Checklist

Repeat referrals are earned through reliable access and useful communication, not awareness.

Before the referral

Make the ask obvious

- **Who** to refer: one line, not a policy
- **When** in the treatment course
- **How**: the exact click or form
- **What happens next**, and by when
- Who to call if it goes wrong

At the handoff

Remove the friction

- Access within a **defined window**
- A triage rule for who is seen first
- No duplicate intake paperwork
- Role clarity: who owns what
- Nothing that adds staff steps

After the visit

Close the loop

- A note that is **brief, relevant, actionable**
- Sent back fast enough to matter
- Says what you changed and what you need
- Never a copy of your full chart
- Readable in under 30 seconds

Why the last column decides everything

Referral loops in primary care are frequently left open, and unclosed loops are a documented source of communication breakdown. A referrer who never hears back stops referring, and reads that silence as the service not working.



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You Are Not Asking for a Favor

Every major obesity guideline already recommends comprehensive care that includes nutrition therapy.

Academy of Nutrition and Dietetics RDNs should coordinate care across primary care, community and workplace settings, and use existing payment channels including the IBT for obesity pathway. Morgan-Bathke M, et al. J Acad Nutr Diet. 2023;123(3):520–545.e10.	Canadian Clinical Practice Guideline Medical nutrition therapy is recommended for weight management in obesity care, delivered by a registered dietitian. Wharton S, et al. CMAJ. 2020;192(31):E875–E891.
Obesity Medicine Association Nutrition counseling is documented as a pillar of the stepwise obesity treatment plan, alongside pharmacotherapy, not replaced by it. Obesity Medicine Association. 2026 Obesity Algorithm®.	Telehealth delivery Technology-enabled MNT is an established, scalable delivery route for weight and chronic disease management, useful where space or geography blocks an embedded model. Hu EA, et al. J Acad Nutr Diet. 2025.

When you propose integration, you are proposing **guideline-concordant care**. Say that out loud.



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Segment 3 | Three Takeaways

Takeaways 7–9

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There is no single right model.

Fit it to volume, workflow, economics and patient need: embedded, contracted, referral, telehealth or shared. Proposing the smallest feasible yes is usually faster than proposing the ideal one.
- 8

Make the desired action obvious: who to refer, how, when, and what happens next.

A clear triage rule, a simple pathway, defined handoffs and role clarity remove the reasons a busy practice quietly stops referring.
- 9

Repeat referrals are earned through reliable access and useful communication.

Not awareness. Close the loop with a note that is brief, relevant and actionable, and remember you are proposing guideline-concordant care.



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Build the Value Proposition

Two sentences. Fill in the brackets before your next conversation.

The Template

For [patient population / practice], I help solve [specific problem] by [RDN intervention], which supports [outcome the decision-maker values].

We can start with [feasible model or pilot] and evaluate [2–4 measures] after [defined period].

Worked Example

“For your patients starting and titrating anti-obesity medication, I help solve GI intolerance and inadequate protein intake through structured nutrition visits between physician appointments, which supports staying on therapy without using your visit slots.
We can start with two contracted half-days and evaluate access time, therapy continuation, and referrer satisfaction after 90 days.”

Pick 2–4 Measures

- Time to first available visit
- Visit completion rate
- Therapy continuation
- A clinical risk you named
- Patient experience score
- Physician capacity returned



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Let's Review Our Takeaways

Nine takeaways, the one-page version to keep.

Segment One

The problems we solve

- 1 Effective medication raises the stakes for nutrition assessment; it does not remove the need.
- 2 Weight change is one outcome, not proof of adequacy or function.
- 3 RDN value spans the whole continuum, especially at initiation, titration and discontinuation.

Segment Two

How we say it

- 4 Start with the stakeholder's problem, not a list of RDN services.
- 5 Describe the outcome created, in the currency your listener owns.
- 6 Make it measurable, and know how the visit actually gets paid for.

Segment Three

Making it easy to say yes

- 7 No single right model; fit it to volume, workflow and economics.
- 8 Make the desired action obvious: who, how, when, and what next.
- 9 Repeat referrals are earned through reliable access and useful communication.



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Segment Four, unofficially

Questions & Conversation

Leslie Golden, MD, MPH · Steph Wagner, MS, RDN, CSOWM · moderated by Melissa Mitri, MS, RDN

Take with you

The nine takeaways, the value proposition template, and the five practice models are all in your handout.

Before you go

We'd love your feedback, please complete the post-event survey.



Selected References

Guidelines & Position Papers

1. Morgan-Bathke M, et al. Medical Nutrition Therapy Interventions Provided by Dietitians for Adult Overweight and Obesity Management: An Academy of Nutrition and Dietetics Evidence-Based Practice Guideline. *J Acad Nutr Diet.* 2023;123(3):520–545.e10.
2. Raynor HA, et al. Position of the Academy of Nutrition and Dietetics: Medical Nutrition Therapy Behavioral Interventions Provided by Dietitians for Adults With Overweight or Obesity, 2024. *J Acad Nutr Diet.* 2024;124(3):408–415.
3. Gigliotti L, et al. Incretin-Based Therapies and Lifestyle Interventions: The Evolving Role of Registered Dietitian Nutritionists in Obesity Care. *J Acad Nutr Diet.* 2025;125(3):408–421.
4. Moloney L, et al. The Effectiveness of Medical Nutrition Therapy in Prevention and Treatment of Chronic Disease: A Position Paper of the Academy of Nutrition and Dietetics. *J Acad Nutr Diet.* 2026;126(2):156–219.
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Trials, Nutrition Care & Delivery

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14. Hu EA, et al. Technology-Enabled Medical Nutrition Therapy. *J Acad Nutr Diet.* 2025.
15. Centers for Medicare & Medicaid Services. National Coverage Determination: Medical Nutrition Therapy (diabetes and renal disease); CPT 97802–97804.
16. Centers for Medicare & Medicaid Services. Intensive Behavioral Therapy for Obesity, HCPCS G0447.





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All webinars will be recorded for free on-demand viewing at eatrightpro.org.
These webinars do not provide CPE credit.*

Webinar Takeaway Resources

1. [2026 & 2025 Academy GLP-1 Webinar Series](#)
2. [WM DPG Webinars, GLP-1 Meet-Ups](#)
3. [GLP-1 and Emerging Incretin Therapies Microcertificate](#)
4. [Best Practices for Registered Dietitians Working with Telehealth Nutrition Companies to Provide Nutrition Services](#)
5. [Nutrition and Obesity Management in the Context of Anti-Obesity Medications: A Blueprint for Action](#)
6. [Nutrition Referral Template](#)

Dietetic Practice Groups

[Weight Management DPG](#)

[Diabetes DPG](#)