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BRIEF CUTTING EDGE REPORT OPEN ACCESS

Clinical Trials and Investigations

Interdisciplinary Weight Management in a Safety-Net Health System: A Pilot Implementation Study

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ABSTRACT

Objective: Despite the high prevalence of obesity and cardiometabolic diseases in safety-net populations, access to intensive, evidence-based lifestyle interventions and scalable implementation strategies remains limited. This study evaluated the effectiveness, acceptability, and feasibility of an interdisciplinary program in an urban safety-net health system.

Methods: This single-center, mixed-methods implementation evaluation assessed LA VIDA, a 6-month interdisciplinary weight management program for medically complex individuals. Outcomes included feasibility, patient engagement, self-rated health, quality of life, physical activity, dietary behaviors, and program satisfaction.

Results: Over 2 years, 95 participants completed the program. They were predominantly female (72.6%) and Latino (78.9%), with a mean age of 50 years, median BMI of 39.2 (IQR: 36.9 to 43.7), and 60% having ≥ 3 comorbidities. Median 6-month weight loss was 5.5% (IQR: −2.6% to −9.9%), with significant improvements in quality of life ($p = 0.0003$), physical health ($p < 0.0001$), moderate-intensity physical activity ($p < 0.001$), and dietary behaviors. Participants reported high satisfaction driven by personalized guidance, increased health knowledge, mindfulness, and the supportive group environment.

Conclusions: LA VIDA was feasible and acceptable and improved patient-reported behaviors and outcomes in a safety-net setting. These findings support it as an effective model for integrated obesity care that combines lifestyle, behavioral, and pharmacologic treatment in the safety net.

1 | Introduction

Obesity and related cardiometabolic diseases are highly prevalent in safety-net populations [1], yet access to intensive, evidence-based lifestyle interventions remains limited. Still, evidence from at least one large study in a safety-net setting demonstrates that such programs can improve cardiometabolic outcomes [2, 3].

In the current era of effective incretin-based pharmacotherapies, obesity care is rapidly evolving. However, medications alone are insufficient to address the behavioral, dietary, and physical activity changes required to optimize cardiometabolic health and sustain long-term weight management. Integrating comprehensive lifestyle support alongside pharmacotherapy is recognized as a critical component of effective obesity treatment [4]. Because safety-net populations are underrepresented in weight

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Study Importance

- What is already known?
  - Disparities in obesity rates in the safety-net system require scalable, effective interventions; yet safety-net populations are underrepresented in weight loss intervention studies.
  - Effective obesity medications like incretins require concurrent behavioral, dietary, and physical activity changes to optimize cardiometabolic health and sustain long-term weight maintenance.
- What does this study add?
  - Comprehensive programs with an interdisciplinary team can be feasibly implemented in the safety-net system for medically complex patients with obesity and are well received by patients.
  - Lifestyle curriculum delivered by an interdisciplinary team in a group setting can improve dietary patterns, physical activity, self-rated health, and quality of life while providing camaraderie and support.
- How might these results change the direction of research or the focus of clinical practice?
  - Health systems should prioritize implementation of integrated, interdisciplinary obesity programs that co-locate nutrition, supervised physical activity, and physician-led care, as these models appear both feasible and effective in safety-net settings.
  - Future research should define the optimal intensity, components, and delivery strategies of obesity interventions in safety-net populations, including how to tailor programs to their higher clinical and social complexity.

loss intervention studies [5], implementation strategies for delivering comprehensive evidence-based obesity care remain poorly understood, perpetuating disparities.

In response to these challenges, LA VIDA was developed within a safety-net health system (61% Medicaid) serving a predominantly Hispanic/Latino population, where obesity prevalence was 48% versus 25% across Los Angeles [6, 7]. The program piloted a model integrating intensive lifestyle support with pharmacotherapy in an under resourced setting. Cohorts were enrolled from January 2024 through December 2025.

The pilot was led by two obesity medicine-certified internal medicine physicians (0.1 FTE each) and one dietitian (0.1 FTE) with grant-funded equipment and a 3WINS Fitness partnership. LA VIDA operated within the existing hospital financial structure, billing visits to insurance under standard protocols.

Eligible participants were adults with obesity (BMI $\geq 30\,kg/m^2$) and cardiometabolic comorbidities, referred by primary care. Entry included a 45-min physician assessment, baseline laboratory testing, and body composition analysis (BIA).

The program utilized a validated group visit model of 10 biweekly sessions over 6 months to support lifestyle change, peer support, and access to care [8–10]. Participants were assigned to English or Spanish cohorts for language-concordant care. Sessions included 1 h of supervised physical activity and 1 h of education reduced per participant feedback. Participants completed one to three individual dietitian visits for tailored medical nutrition therapy.

The curriculum was grounded in the six pillars of lifestyle medicine [11]. Nutrition education included food demonstrations provided by CalFresh Healthy Living while 3WINS Fitness tailored on-site exercise instruction to individual ability levels [12]. Participants received resistance bands to reinforce at-home resistance training.

The behavioral health component, developed by a licensed clinical psychologist, addressed psychological and contextual drivers of eating behaviors in high-stress safety-net populations. Content targeted maladaptive thoughts, emotional eating, and challenges with sustained motivation.

The curriculum integrated cognitive-behavioral therapy and acceptance and commitment therapy, targeting the cognitive-behavioral cycle and incorporating mindfulness, values clarification, and committed action. Sessions included SMART goal setting, structured exercises, and written materials to facilitate skill acquisition and immediate application.

2 | Methods

A mixed-methods design was employed to integrate quantitative survey data with qualitative interview data capturing participant perspectives on program effectiveness, acceptability, and feasibility. The evaluation was approved by UCLA (#23-5252) and Olive View (#2100652-6) IRBs.

Quantitative data were collected via surveys at program entry and completion, assessing demographics and health behaviors [13]. Perceived neighborhood food environment was assessed using three items evaluating healthy food availability, affordability, and quality [14]. Self-rated health was measured using the Lifestyle Assessment Form [15], and quality of life was measured using a single-item Likert scale [16]. Dietary behaviors were assessed through reported weekly consumption of specific food items [17, 18], and physical activity using two IPAQ items [19].

Participation satisfaction was assessed at program completion across four domains (program structure, physical activity, nutrition, physician interaction). Attendance barriers were evaluated through end-of-program surveys and qualitative interviews.

Survey data were managed using REDCap [20, 21]. Demographic and baseline characteristics were summarized using descriptive statistics. Continuous variables were assessed for normality. Because all continuous variables demonstrated non-normal distributions, Wilcoxon signed rank tests were used for subsequent analyses. All quantitative analyses were conducted using SAS 9.4 (SAS Institute Inc.).

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TABLE 1 | Baseline participant demographics, socioeconomic characteristics, clinical comorbidities, and weight management history.

Category	*N*	%
Current age, mean (SD) [range]	50.1 (12.8) [19.0–75.0]	
Gender		
Female	69	72.6%
Male	26	27.4%
Race		
White, non-Hispanic	1	1.1%
Black, non-Hispanic	1	1.1%
Asian	3	3.2%
Latino	75	78.9%
Other	15	15.8%
Marital status		
Married or living as married	45	47.4%
Divorced/Widowed	17	17.9%
Single	32	33.7%
Missing	1	1.1%
Language		
Spanish	47	49.5%
English	48	50.5%
Education		
Less than a high school degree	22	23.2%
High school degree	26	27.4%
Some college	26	27.4%
College/more than college	21	22.1%
Employment status		
Employed	45	47.4%
Unemployed	28	29.5%
Student	4	4.2%
Retired	6	6.3%
Disabled	12	12.6%
Family size		
0	60	63.2%
1–2	27	28.4%
3–4	6	6.3%
>4	2	2.1%
Comorbidities		
Hypertension	49	51.6%
Hyperlipidemia	44	46.3%
Pre-diabetes	41	43.2%
Type 2 diabetes	22	23.2%
Obstructive sleep apnea	24	25.3%
MASLD	11	11.6%
Osteoarthritis of any joint	21	22.1%
Anxiety	29	30.5%
Depression	38	40.0%
Number of comorbidities		
0	3	3.2%
1	8	8.4%
2	27	28.4%
3	21	22.1%
4	23	24.2%
5 or greater	13	13.7%
Reported previous weight loss attempts		
None	37	38.9%
Structured diet	33	34.7%
Self-driven diet	43	45.3%
Medications	54	56.8%
Weight Note loss surgery/ procedure	8	8.4%
Obesity medication use at program start		
No semaglutide, tirzepatide, or phentermine	56	58.9%
Phentermine	3	3.2%
Semaglutide	26	27.3%
Tirzepatide	10	10.5%

Upon program completion, participants were invited to in-depth qualitative interviews exploring experiences with obesity and its treatment within the health system and LA VIDA. Interviews were conducted by trained interviewers, audio-recorded, professionally transcribed, and translated into English when necessary. Participants received compensation for their time.

An inductive thematic analysis was conducted. Transcripts were reviewed for familiarization, then open-coded and organized into themes and subthemes [22]. Coders met to ensure alignment. ATLAS.ti Scientific Software Development GmbH was used for analysis to support data organization and traceability.

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3 | Results

Over the 2-year pilot, 452 referrals were received from primary care providers and 132 participants attended at least one group session. Ninety-five participants attended both the first and final program sessions and were included in the evaluation. Participants attended an average of 7 of 10 sessions, with the most reported barriers being acute illness (41.1%), caregiving responsibilities (37.9%), and work-related conflicts (29.5%).

3.1 | Participant Characteristics

Participants were predominantly female (72.6%) and Latino (78.9%), with a mean age of 50.1 (range 19–75). Most participants (63.2%) lived alone, 23.2% had less than a high school education, and nearly half were employed (47.4%).

Baseline median BMI was 39.2 (IQR: 36.9 to 43.7). Three or more cardiometabolic comorbidities were present in

TABLE 2 | Changes in quality of life, subjective physical health, physical activity, and food intake from baseline to program completion.

	Beginning of program		End of program		
	N	**%**	***N***	**%**	***p***
Quality of life					
Very poor	2	2.1%	2	2.1%	**0.0003**
Poor	7	7.4%	4	4.2%	
Neither poor nor good	40	42.1%	18	18.9%	
Good	39	41.1%	58	61.1%	
Very good	7	7.4%	12	12.6%	
Subjective physical health					
Poor	28	29.5%	6	6.3%	**< 0.0001**
Fair	44	46.3%	27	28.4%	
Good	21	22.1%	45	47.4%	
Very good	2	2.1%	14	14.7%	
Excellent	0	0.0%	2	2.1%	
Time per week spent on moderate physical activities					
< 30 min	44	46.3%	23	24.2%	**< 0.0001**
31–60 min	31	32.6%	31	32.6%	
91–150 min	12	12.6%	20	21.1%	
151–300 min	4	4.2%	13	13.7%	
> 300 min	4	4.2%	7	7.4%	
Food item serving per week	**Mean**	**Median**	**Mean**	**Median**	***p***
Fruits	4.1	3.0	5.3	5.0	**0.0025**
Vegetables	4.3	3.0	5.0	5.0	**< 0.0001**
Fried potatoes	1.5	1.0	0.9	1.0	**0.0001**
Soda	2.2	1.0	1.0	0.0	**< 0.0001**
Sweetened fruit drinks	1.3	0.0	1.0	0.0	**0.1106**
Fast food	1.9	2.0	1.3	1.0	**< 0.0001**
Coffee with sugar	3.2	2.0	2.2	1.0	**0.0004**
Frozen desserts	1.2	1.0	0.5	0.0	**< 0.0001**
Sweet pastries	1.9	2.0	1.3	1.0	**0.0003**
Fried food	2.3	2.0	1.2	1.0	**< 0.0001**
Red meats	2.0	2.0	1.9	2.0	**0.4387**
Plant based proteins	1.6	1.0	2.9	3.0	**< 0.0001**

Note: Statistical significance was defined as $p < 0.05$ (in bold).

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TABLE 3 | Participant satisfaction, acceptability, and perceived impact of the LA VIDA Program.

	Mean	SD
Overall program satisfaction and perceived benefit		
Overall, the expectations I had of LA VIDA were met	4.61	0.76
Overall, the material that was presented was new information for me	4.53	0.75
Overall, the benefits were worth the time and effort I put forth to attend LA VIDA	4.78	0.53
The information presented was practical and helpful in my daily life	4.75	0.54
LA VIDA built a sense of community between me and the other participants	4.42	0.88
My view of my weight and physical health improved because of LA VIDA	4.66	0.63
I am physically healthier from being in LA VIDA	4.59	0.68
LA VIDA has improved my outlook on my life and health	4.67	0.61
I would recommend a friend or family member to participate in LA VIDA	4.83	0.43
Nutrition knowledge and behavior change		
The nutrition information presented was new to me	4.49	0.72
Individual visits with the dietitian were a valuable part of LA VIDA	4.52	0.88
I have changed my eating habits because of LA VIDA	4.70	0.64
I shared what I learned with those in my household	4.63	0.78
I am now mindful of my protein intake	4.77	0.45
I am now mindful of how situations, feelings, and thoughts affect my food choices	4.74	0.62
I have a better understanding of how to read a nutrition label	4.70	0.68
I will be able to maintain my eating habits as I learned in LA VIDA	4.66	0.67
Physician interaction and personalized care		
Working with the doctors in this program was a good experience	4.83	0.48
The doctors helped me to make changes that are sustainable in my life	4.82	0.49
The doctors helped create a treatment plan that was personalized to fit my needs and preferences	4.70	0.71
Individual physician visits were a valuable part of LA VIDA	4.65	0.71
The medications the doctors started during LA VIDA helped me to reach my weight and health goals	4.53	0.84
Physical activity engagement and self-efficacy		
I enjoyed exercising as a part of LA VIDA	4.60	0.84
I now exercise regularly, utilizing what I learned in LA VIDA	4.32	0.95
I feel more physically fit now compared to before I started LA VIDA	4.49	0.84
I now have a better understanding of how to exercise for health benefits	4.71	0.58
I am now closer to reaching the physical activity guidelines (30 min of moderate-intensity exercise 5 days per week) and 2 days of resistance training	4.45	0.84

Note: Response scale: 1 = Strongly disagree, 2 = Disagree, 3 = Uncertain, 4 = Agree, 5 = Strongly agree.

60% of participants, including hypertension (51.6%), prediabetes (43.2%), type 2 diabetes (23.2%), obstructive sleep apnea (25.3%), and metabolic dysfunction-associated steatotic liver disease (MASLD) (11.6%) (Table 1). Median weight loss at 6 months was 5.5% (IQR: −2.6% to −9.9%), with 54.7% of participants achieving clinically significant weight loss (≥ 5% total body weight loss).

Overall, 53.7% of participants reported adequate food access but limited choice. Responses reflected uncertainty about the neighborhood food environment, with neutral to uncertain responses for convenience (mean = 3.3, SD = 0.7) and affordability (mean = 3.0, SD = 0.6) of healthy foods. Participants generally disagreed that healthy foods were difficult to find (mean = 2.1, SD = 1.0) or of low quality (mean = 2.4, SD = 1.0).

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Most reported prior attempts at weight loss (e.g., diets, medications, surgery). At entry, 58.9% of participants were not on obesity medications. Among those on pharmacotherapy, GLP-1 receptor agonists were most common, including semaglutide (27.3%) and tirzepatide (10.5%) (Table 1).

3.2 | Changes in Quality of Life, Physical Health, Physical Activity, and Dietary Intake

Significant improvements were observed in quality of life ($p = 0.0003$), self-rated physical health ($p < 0.0001$), and time spent in physical activity ($p < 0.001$). The proportion reporting < 30 min per week of moderate-intensity physical activity decreased from 46.3% to 24.2% by program completion (Table 2).

Consumption of fruits, vegetables, and plant-based protein sources increased significantly. Intake of fried potatoes, soda, fast food, frozen desserts, pastries, and other fried foods decreased significantly (Table 2).

3.3 | Program Satisfaction

Most participants agreed that the program provided practical information, was worth their time and effort, and improved their sense of community, physical health, and outlook on life. Participants reported improved skills in nutrition label reading and mindful eating, perceived treatment plans as personalized and sustainable, and reported greater understanding of the health benefits of exercise (Table 3).

3.4 | Qualitative Findings

Analysis of 22 in-depth interviews identified key themes characterizing participant experiences. Participants frequently expressed the value of acquiring actionable health knowledge.

> I learned a lot of things in the program... I was taking notes on how to eat... everybody has a smartphone, a computer at home, but you are not looking [at] 'how food affects the body'... Coming here and having that information—I was impressed. It was something I liked.

Participants emphasized the importance of social support and accountability fostered by the group-based format.

> When you are alone, it is impossible...that was clear in the group because everyone said the same thing—that they needed company to be able to continue.

Participants also described increased confidence and agency related to their health.

> If I hadn't entered the LA VIDA program, I wouldn't be as I am... Thanks to the LA VIDA program, I have made a key change to my health.

4 | Discussion

This mixed-methods evaluation assessed the feasibility of implementing an interdisciplinary obesity program in a large urban safety-net healthcare setting. LA VIDA addressed a critical gap in comprehensive obesity care by integrating evidence-based lifestyle medicine with pharmacologic and behavioral interventions. These findings provide practical insights for health systems aiming to implement similar models.

Demand for the program was substantial, reflecting unmet need. Program capacity and participation were limited by restricted scheduling, with sessions offered only once weekly in the morning. Engagement was further affected for referred participants by external disruptions, including the January 2025 Los Angeles wildfires and spring 2025 immigration enforcement activity, which reduced enrollment and attendance. Despite these barriers, participants in the program showed strong engagement, with high attendance and completion rates.

Participants were medically complex, with high cardiometabolic comorbidity and low baseline self-rated health. Over 6 months, they showed significant improvements in self-rated physical health, quality of life, moderate-intensity physical activity, and diet. While this study emphasizes implementation outcomes, the program achieved weight loss comparable to that reported in comprehensive obesity treatment programs [23], with a majority of participants achieving clinically significant weight loss over 6 months. Detailed analyses of the factors associated with weight loss and cardiometabolic outcomes will be reported separately. Qualitative findings contextualized these patient-reported outcomes, highlighting the group format, interdisciplinary team, and supervised activity as key drivers of social support, accountability, and self-efficacy.

This evaluation has several limitations. Outcomes were based on self-reported measures, as objective assessments of fitness, functional capacity, or cardiometabolic endpoints were not yet available. Findings reflect participants who attended sessions and completed follow-up surveys, introducing potential selection bias.

As incretin-based pharmacotherapy becomes increasingly available for obesity treatment, comprehensive care models remain essential. Pharmacotherapy is intended to complement—not replace—lifestyle-based interventions. Programs such as LA VIDA are uniquely positioned to support this approach by providing structured behavioral, nutritional, and physical activity interventions that promote sustained improvements in weight-related health outcomes, particularly for patients with complex care needs.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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