AASM American Academy of SLEEP MEDICINE®

ADVANCING HEALTHY WEIGHT MANAGEMENT IN SLEEP MEDICINE:

Findings and Recommendations from the AASM Obesity Management Strategy Summit

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A report by the 2025-2026 American Academy of Sleep Medicine Obesity Management Task Force: Timothy I. Morgenthaler, MD (Chair); Rafael Sepulveda, MD (Vice Chair); Anuja Bandyopadhyay, MD (AASM Board Liaison); Nathan Nowalk, MD; Raed Hawa, MD; Safia Khan, MD; Nícollas Mozart Vieira, MD; Lindsay Stager, PhD; Mira Tadros, DO; Xinhang Tu, MD; Brian Wojeck, MD; Kathleen Fitzgerald, MSEd, PMP (AASM staff liaison); Matthew Anastasi, RPSGT, FAAST, FAASM (AASM staff liaison)

1. Introduction

Obesity and sleep disorders, particularly obstructive sleep apnea (OSA), are deeply interconnected clinical conditions. Sleep medicine clinicians have long managed the downstream consequences of obesity on sleep-disordered breathing and related cardiometabolic risk. In recent years, however, the rapid emergence and widespread uptake of effective obesity management medications (OMMs) have fundamentally altered the clinical landscape. These therapies have the potential to improve both weight management outcomes and OSA severity, raising important questions about the appropriate role of obesity management in sleep medicine.

Recognizing the clinical, operational, and professional implications of this shift, the American Academy of Sleep Medicine (AASM) Board of Directors charged the Obesity Management Task Force (OMTF) with helping the AASM think strategically about how sleep medicine should engage with obesity management. Specifically, the task force was asked to: (1) discover emerging best practices for weight management among sleep clinicians; (2) develop practical OMM implementation resources for AASM members; and (3) propose a long-term strategy to guide the AASM's engagement in this area.

The Obesity Management Strategy Summit was convened to advance this charge. Building on a year of task force work—including development and consolidation of clinician and patient resources on a range of topics including the intersection of obesity and sleep, weight management, and weight stigma; modeling of obesity management approaches in diverse sleep practice settings; and a national survey of AASM members on their practices and beliefs related to OMMs—the summit was designed as a focused, in-person working meeting. Its purpose was not to redefine sleep medicine as obesity medicine, but to clarify how sleep clinicians can responsibly and effectively engage in obesity management to improve patient care, respect professional scope, and align with institutional and health system realities. While the summit and task force work were framed broadly around weight management in sleep medicine, the scope of this effort was intentionally focused on the intersection of weight management and obstructive sleep apnea. The task force did not explicitly address other domains of sleep health where bidirectional relationships with weight and metabolism may also be relevant. Acknowledging this scope early is important, as many of the principles described here may have broader applicability across sleep health, even though they were developed within the context of OSA care.

The primary objectives of the summit were to synthesize member needs, identify gaps and barriers limiting implementation, generate and prioritize potential approaches, and articulate clear, board-ready recommendations related to weight management in sleep medicine settings. The summit focused on adult sleep medicine practice in the United States, with attention to a range of practice settings and readiness levels. Detailed pharmacologic management decisions and disease-specific obesity treatment guidelines outside the context of sleep medicine were considered out of scope.

2. Summit Overview and Methods

2.1 Summit Details and Participants

The Obesity Management Strategy Summit was held on March 14, 2026, at AASM Headquarters in Darien, Illinois, and was organized by the AASM Obesity Management Task Force in collaboration with AASM staff. Participants included members of the task force, AASM leadership and staff, and invited external stakeholder representatives including:

- John Morton, MD — American Board of Obesity Medicine (ABOM)
- Brianna Johnson-Rabbett, MD — American Board of Obesity Medicine (ABOM)
- Deepa Handu, PhD — Academy of Nutrition and Dietetics (eatright.org)
- Monica Mallampalli, PhD — Alliance of Sleep Apnea Partners (ASAP)
- Tracy Zvenyach, PhD — Obesity Action Coalition (OAC)
- Nicholas Pennings, DO — Obesity Medicine Association (OMA)
- Sanjay R. Patel, MD — University of Pittsburgh

This multidisciplinary approach was intentional and reflected the task force's commitment to collaboration, shared learning, and avoidance of siloed approaches.

2.2 Program Structure

The summit followed a structured, facilitated agenda that combined foundational presentations, small-group discussions, and consensus-building exercises. Foundational sessions reviewed the task force's prior work and presented findings from the national AASM membership survey examining readiness, barriers, and implementation needs related to obesity pharmacotherapy in sleep medicine.

The program was guided by an implementation-focused framework that emphasized readiness, structural capacity, and practical support needs. Participants engaged in facilitated table discussions to identify key gaps, brainstorm potential approaches, and refine ideas through iterative discussion. Visual capture of ideas on whiteboards enabled real-time synthesis and collective sense-making.

2.3 Priority-Setting Approach

Priority setting followed a multi-step, consensus-driven process. After identifying major gaps and unmet needs, participants generated a broad set of potential actions and strategies. These ideas were then clustered into thematic areas and subjected to multi-voting to identify the highest-priority opportunities. Finally, prioritized themes were assessed using an effort-impact framework to distinguish near-term actions from longer-term strategic initiatives. This structured approach was designed to balance ambition with feasibility and to produce actionable recommendations for future planning and implementation.

3. Session Findings: Gap Identification and Prioritization

During the summit, participants worked through a structured, visual prioritization process to identify and organize gaps. For each gap category, ideas were generated collaboratively, then prioritized using colored dot voting. A voting system was used to indicate relative priority and strength of support, identifying actions felt to be appropriate for near-term execution (0–12 months) and actions better suited for strategic development over a 1–3-year horizon. The sections below synthesize the content of those exercises.

3.1 Integrated Guidelines

Summary of Identified Gap

The absence of integrated, obesity management specific guidance for sleep medicine was identified as the most significant overarching gap. Participants consistently noted uncertainty about how sleep medicine should align with broader multidisciplinary obesity care, leading to variability in practice and hesitation in implementation.

Relative Priority

Integrated guidelines received the highest overall priority ranking. However, the distribution of votes favors the 1–3-year horizon, signaling that while this domain is critically important, it is viewed as a complex, strategic undertaking rather than an immediate deliverable.

Near-Term Opportunities

- Develop interim frameworks or translational guidance for obesity management that are tailored to sleep medicine
- Convene expert consensus discussions with the organizations that participated in the Summit to clarify scope, principles, and foundational expectations
- Align terminology and conceptual models across sleep and obesity care discussions

Strategic Opportunities

- Formal guideline development for obesity management in sleep medicine in collaboration with organizations represented at the summit (e.g., ABOM, Academy of Nutrition and Dietetics, OMA, and patient advocacy partners), leveraging their established expertise and existing evidence frameworks
- Articulate how sleep medicine should engage with obesity management as a co-evolving domain of care—defining where sleep clinicians lead, where they partner, and how responsibilities are shared across multidisciplinary teams
- Publication and dissemination of obesity-specific sleep medicine guidelines

3.2 Operational Efficiency

Summary of Identified Gap

Operational complexity—including workflow inefficiencies, insurance requirements, and documentation burden—was identified as a major near-term barrier to implementation. Participants emphasized that these challenges directly impede clinician adoption despite clinical readiness.

Relative Priority

Operational efficiency ranked among the highest priority domains and showed an overwhelming concentration of "Soon" votes, with no corresponding longer-term weighting. This reflects strong consensus that actionable solutions are both feasible and urgently needed.

Near-Term Opportunities

- Standardized documentation templates and clinical workflows
- Prior authorization tools and payer navigation resources
- From a practice-level perspective, provide practical recommendations on the infrastructure and team support needed to integrate obesity management into a sleep clinic, from a basic setup to an ideal model
- EMR optimization strategies specific to obesity-related sleep care
- Practical workflow support materials for clinical teams

Strategic Opportunities

- Integration of operational best practices into broader sleep medicine resources
- Alignment of efficiency tools with future guideline and accreditation efforts
- Data-informed refinement of workflows as adoption scales

3.3 Accreditation

Summary of Identified Gap

Participants identified accreditation as an important structural lever for defining standards and reinforcing the role of sleep medicine in obesity care. This could involve establishing dedicated program standards for programs offering integrated sleep-obesity care. However, there was recognition of the complexity and downstream implications of modifying accreditation frameworks.

Relative Priority

Accreditation ranked highly overall, with votes leaning toward the 1–3-year horizon while still showing some near-term interest. This pattern reflects strong importance but is tempered by feasibility and governance considerations.

Near-Term Opportunities

- Exploratory assessment of how obesity-related care fits within existing accreditation models
- Stakeholder engagement to define potential accreditation implications
- Identification of accreditation-relevant gaps in current practice

Strategic Opportunities

- Board-level discussion and direction regarding accreditation evolution
- Development of obesity-related standards within sleep accreditation frameworks
- Alignment of accreditation criteria with integrated guidelines and quality measures

3.4 Educational Resources

Summary of Identified Gap

There is an immediate need for practical, scalable educational resources to support clinicians and patients as obesity-related care expands within sleep medicine. Participants emphasized gaps in both clinician-focused and patient-facing materials.

Relative Priority

Educational resources were assigned a moderate-to-high priority ranking but demonstrated the strongest signal for immediate action. All votes were concentrated in the "Soon" category, indicating high readiness and feasibility.

Near-Term Opportunities

- Development of patient education materials and communication tools on the intersection between obesity and sleep, Patient-directed care participation, and the role of OMMs in improving sleep health
- Clinician-focused educational modules and recorded case-based learning focused on implementation of weight management strategies (including OMMs) and non-stigmatizing approaches to obesity medicine
- Modular training resources adaptable to different practice settings
- Partner with summit-participating professional societies and advocacy organizations that already maintain high-quality educational content (e.g., ABOM, OMA, Academy of Nutrition and Dietetics, and patient advocacy partners) to curate, adapt, and share relevant materials rather than duplicating effort

Strategic Opportunities

- Expansion of educational offerings aligned with future guidelines
- Integration of education into accreditation and quality initiatives
- Ongoing refresh of materials as evidence and policy evolve

3.5 Advocacy

Summary of Identified Gap

Advocacy efforts related to obesity-related sleep care remain fragmented, limiting progress in access, coverage, and consistent policy alignment.

Relative Priority

Advocacy was viewed as an important but mid-tier priority, with a relatively even split between near-term and longer-term horizons. Participants recognized both the need for early engagement and the reality that meaningful impact requires sustained effort.

Near-Term Opportunities

- Engagement with existing advocacy organizations and coalitions
- Engagement with summit-participating organizations and patient advocacy partners to identify shared access and coverage barriers, align messaging, and coordinate early advocacy efforts
- Identification of priority access and coverage issues
- Development of consistent advocacy messaging

Strategic Opportunities

- Long-term policy engagement to influence coverage and reimbursement
- Alignment with national obesity and sleep advocacy efforts
- Use of evidence and outcomes data to support policy positions

3.6 Patient Education and Engagement

Summary of Identified Gap

Patient engagement strategies are underdeveloped, particularly with respect to patient-centered communication, people-first language, and meaningful incorporation of patient perspectives.

Relative Priority

Patient education and engagement ranked lower relative to operational and structural domains, with votes favoring the 1–3-year horizon. This suggests recognition of importance but acknowledgment that deeper engagement requires thoughtful design.

Near-Term Opportunities

- Development of accessible patient education resources
- Incorporation of people-first language into materials and messaging
- Early inclusion of patient perspectives in resource development
- Curate and adapt patient-focused resources from summit-participating professional societies and advocacy organizations that already emphasize stigma reduction and patient-centered communication

Strategic Opportunities

- Co-design engagement strategies with patients and caregivers
- Integration of patient engagement into care pathways and quality initiatives
- Sustained evaluation of patient-reported outcomes and experience

3.7 Research

Summary of Identified Gap

While recognized as essential for long-term credibility and policy influence, research gaps—particularly related to real-world outcomes and cost-effectiveness—were seen as less immediately actionable.

Relative Priority

Research received the lowest overall priority ranking and was strongly weighted toward the 1–3-year horizon, reflecting its foundational but longer-term role.

Near-Term Opportunities

- Identification and articulation of key research gaps
- Synthesis and communication of existing evidence
- Alignment of research questions with advocacy and guideline needs

Strategic Opportunities

- Generation of real-world outcomes and cost-effectiveness data
- Collaborative research initiatives with external partners

Use of research findings to support guidelines, accreditation, and policy

4. Proposed Roadmap

The findings above informed the development of a proposed roadmap and set of recommendations described in the following section.

The summit discussions and prioritization exercises were explicitly designed to inform a practical, staged roadmap for integrating obesity management into sleep care. The roadmap below reflects the task force's synthesis of summit findings and recognizes obesity as a chronic disease that commonly intersects with sleep disorders and sleep health outcomes. It distinguishes near-term actions suitable for immediate execution from strategic initiatives requiring longer-term development, partnership, or policy alignment. Together, these elements are intended to support member needs, advance patient care, and help clarify what is needed for sleep medicine to respond effectively in this evolving space.

4.1 Near-Term Actions (0–12 Months)

Near-term actions emphasize high-impact, feasible efforts that address commonly cited barriers and are well-suited for early implementation given current resources, partnerships, and operational readiness. These actions were consistently identified by summit participants as areas where timely progress would meaningfully support clinicians and patients. Where feasible, these efforts should leverage existing high-quality resources and partnerships established through the summit, rather than duplicating work already underway in aligned professional societies and advocacy organizations.

Clinical Implementation and Workflow

- Develop practical, clinic-ready tools illustrating how obesity management conversations and assessments can be incorporated into routine sleep medicine visits
- Provide sample workflows, documentation templates, and role delineation examples that reflect diverse practice settings and staffing models
- Create brief educational resources focused on initiating respectful, non-stigmatizing, patient-centered discussions about obesity within sleep clinics, including attention to communication practices, workflows, equipment, and seating that help create a physically and emotionally welcoming care environment

Access, Insurance, and Health System Support

- Produce standardized templates for medical necessity documentation, prior authorization requests, and appeals related to obesity management
- Develop concise reference materials summarizing common payer requirements and administrative considerations relevant to sleep practices
- Offer guidance on task delegation, highlighting components of obesity care that can be supported by non-physician team members

Patient Education and Engagement

- Adapt, co-brand, or co-create patient-facing resources with patient advocacy organizations and aligned professional societies when high-quality materials already exist
- Create or curate reliable, accessible patient-facing educational materials as needed to address identified gaps, including resources that link obesity management to sleep health outcomes
- Ensure consistent use of people-first, non-stigmatizing language across all educational and professional resources
- Clarify that obesity management strategies should be individualized and that not all patients require the same intensity or modality of intervention

Professional Messaging and Advocacy Foundations

- Integrate explicit attention to stigma and bias into educational materials and communications
- Strengthen advocacy efforts related to access to obesity treatments and services through collaboration with aligned professional societies and patient advocacy organizations, including support for policies that recognize obesity as a chronic disease and promote equitable access to care

4.2 Strategic Initiatives (1–3 Years)

Strategic initiatives reflect areas where summit participants saw substantial opportunity but recognized the need for sustained effort, coordination, or external partnership. These initiatives may be pursued through collaboration with aligned professional societies and advocacy organizations, as appropriate to scope, governance, and shared goals.

Education, Training, and Workforce Development

- Develop scalable training resources, such as recorded simulated encounters or virtual shadowing experiences, to demonstrate effective obesity management workflows in sleep medicine, incorporating patient perspectives, lived experience, and real-world clinical scenarios
- Create modular educational curricula addressing the core components (“pillars”) of obesity management and their relevance to sleep practice, including obesity treatment as part of OSA care, lifestyle counseling, and initiation and management of obesity medications indicated for OSA when appropriate
- Establish mentorship or peer-to-peer learning programs to support clinicians and practices as they adopt new care models
- Advocate for incorporation of obesity management competencies into sleep medicine training expectations, fellowship requirements, certification examinations, and longitudinal knowledge assessment, emphasizing a comprehensive approach rather than a narrow focus on any single therapy

Systems, Coverage, and Policy Engagement

- Establish a centralized, regularly updated resource describing coverage and authorization requirements across Medicare, Medicaid, and commercial payers
- Engage in national advocacy efforts aimed at improving access to evidence-based obesity treatments and reducing administrative burden
- Review and update relevant AASM clinical practice guidelines, clinical guidance statements, quality measures, accreditation standards, and public education resources to incorporate evidence-based obesity management where appropriate, prioritizing OSA-related materials such as inpatient OSA management, medical therapy of OSA, adult OSA screening and quality measures, diagnostic testing updates, and the public education

toolkits. Include patient representatives from obesity advocacy organizations in this review to reduce obesity stigma and bias and to ensure that recommendations and materials support practical, respectful, and helpful approaches to care.

- Explore digital tools or platforms that could assist practices in navigating reimbursement and authorization processes

Patient Partnership and Public Engagement

- Engage patients and patient advocacy groups, including those represented at the summit, in the co-development, co-branding, or adaptation of educational resources and outreach strategies
- Launch awareness initiatives that articulate the supportive role of sleep medicine in comprehensive obesity care
- Strengthen partnerships with multidisciplinary organizations and coalitions addressing obesity prevention and treatment, building on relationships established through the summit

4.3 Implementation Considerations

The task force anticipates that successful implementation of this roadmap will require consideration of several key questions, including:

- Prioritization and sequencing of near-term versus strategic initiatives
- Appropriate formats for endorsed resources (e.g., toolkits, white papers, webinars, or online hubs)
- Alignment of proposed activities with existing programs and advocacy efforts
- Identification of opportunities for partnership or collaboration to extend impact while respecting professional scope

The roadmap is intended to support decision-making about next steps and inform how obesity management efforts in sleep medicine may be advanced over time.

5. Implementation and Translation Considerations for the Roadmap

5.1 Barriers to Adoption

Successful implementation of obesity management within sleep medicine will be influenced by several persistent barriers. These include operational complexity, such as workflow disruption, documentation burden, evolving payer requirements, and particularly practice operational costs. Implementation will require investments in personnel, infrastructure, and education. Clinicians may also face uncertainty regarding scope of practice, particularly in settings where multidisciplinary obesity care is already established. Variability in institutional support, limited access to trained team members, and gaps in familiarity with evolving obesity pharmacotherapy may further constrain adoption. Finally, stigma and discomfort in addressing obesity in a clinical setting remain important, often under-recognized, challenges.

5.2 Facilitators and Enablers

Several factors may accelerate successful integration of obesity management into sleep medicine practice. Availability of clinic-ready tools, including standardized documentation templates and workflow models, can reduce operational

friction and promote early adoption. Collaboration with multidisciplinary partners—including obesity medicine specialists, endocrinologists, and bariatric programs—can extend capability while maintaining appropriate scope. Educational resources that emphasize practical application, patient-centered communication, and stigma reduction can build clinician confidence. Finally, alignment with broader health system priorities, including cardiometabolic risk reduction and population health, can facilitate institutional support. Public health emphasis backed by policy and financial enablement would undoubtably reduce headwinds.

5.3 Metrics and Indicators of Progress

Measurement will be essential to guide implementation, assess impact, and inform refinement. A separate task force might assist in developing quality metrics. Conceptually, early indicators may include process measures such as frequency of obesity-related counseling, utilization of documentation templates, and rates of appropriate referral to weight management services. Intermediate measures could include prescription or referral patterns related to obesity management therapies and patient engagement with recommended interventions. Longer-term outcomes may include changes in weight, sleep apnea severity, treatment adherence, and patient-reported outcomes. Selection of metrics should balance feasibility with clinical relevance and align, where possible, with existing quality and reporting frameworks.

5.4 Implications for the Field

The convergence of obesity medicine and sleep medicine represents one of several important strategic developments facing the field. This convergence is being driven by the bidirectional biology linking obesity and sleep disorders, the growing evidence that intentional weight loss improves sleep outcomes, and the emergence of obesity management pharmacotherapy as a potential disease-modifying treatment for obstructive sleep apnea in adults with obesity. For sleep medicine, this represents more than the addition of a new treatment option. It invites a broader reflection on the identity and future scope of the field. The advances that have defined modern sleep medicine—diagnostic testing, PAP therapy, oral appliance therapy, surgical referral, neurostimulation, and longitudinal management of sleep disorders—remain foundational. At the same time, the evidence now suggests that optimal care for many patients will require attention not only to airway patency and sleep physiology, but also to the metabolic and weight-related drivers that contribute to sleep-disordered breathing and poor sleep health.

This transition should not be viewed as a repudiation of current sleep medicine practice. Rather, it represents a natural evolution of the field: from diagnosing and treating sleep disorders in isolation toward addressing the broader physiologic, behavioral, and cardiometabolic context in which those disorders occur. This broader perspective has been evident for many years, but new OMMs present agency in an important area not previously accessible. Obesity is among the most important modifiable risk factors for OSA, while insufficient sleep, circadian disruption, and poor sleep quality may contribute to weight gain and impaired metabolic health. Sleep health and weight health are therefore mutually reinforcing domains of care. Sleep medicine does not need to “become” obesity medicine to respond to this reality; however, the field will need to consider how and how much obesity care becomes part of sleep practice through counseling, referral, co-management, medication monitoring, or prescribing in selected settings. The appropriate model will vary across practices and communities, but the implications for clinical workflows, interdisciplinary partnerships, and sleep medicine training are substantial.

The SURMOUNT-OSA trials and the approval of tirzepatide for adults with moderate-to-severe OSA and obesity mark an important inflection point. The significance of these developments is not that pharmacotherapy will replace PAP therapy (or other airway patency therapies). PAP remains highly effective, immediately available, and essential for many patients. Rather, the significance is that treating obesity can meaningfully alter the severity and trajectory of OSA itself, along with many cardiometabolic risk factors. Sleep medicine is therefore moving from a model focused

primarily on diagnosis and device-based treatment toward a more integrated model of longitudinal, multimodal care. In this model, PAP, oral appliances, surgery, neurostimulation, lifestyle intervention, obesity management medications and other pharmacotherapy, bariatric surgery, insomnia treatment, circadian stabilization, and cardiometabolic risk management may all have roles, depending on the patient.

This evolution will require thoughtful leadership. Many sleep specialists were trained in a model centered on polysomnography, diagnosis, PAP initiation, and adherence management. Expanding the field to include obesity assessment, respectful weight-related conversations, structured referral pathways, and greater familiarity with anti-obesity therapies may feel unfamiliar or burdensome, particularly in practice settings already facing workforce, documentation, and reimbursement pressures. At a foundational level, all sleep clinicians should understand the relationship between obesity and sleep disorders and communicate about weight in a non-stigmatizing, evidence-based manner. At more advanced levels, some practices may develop formal co-management pathways or incorporate obesity treatment directly. The opportunity is not to redefine sleep medicine away from its core mission, but to extend that mission toward more complete, individualized, and disease-modifying care.

5.5 Anticipated Effects of Implementation

If the proposed strategies and initiatives are successfully implemented, several changes may be expected. Patients may experience more coordinated care that links sleep health with weight management strategies, potentially improving both outcomes. Sleep practices may evolve toward more team-based models, incorporating non-physician support roles and structured workflows. Educational and operational resources may become more standardized across practices. At an organizational level, clearer alignment between sleep medicine and broader health system priorities may emerge, supporting sustainability and scale.

5.6 Risks of Inaction

Failure to engage in obesity management in a thoughtful and coordinated manner may result in missed opportunities to improve patient outcomes and damage the field of sleep medicine. Sleep clinicians may become less central to the care of patients with obstructive sleep apnea as other specialties expand their role in obesity treatment. Variability in practice may persist, contributing to inequities in access and quality and healthcare outcomes. In addition, lack of engagement may limit the ability of sleep medicine to contribute to evolving policy discussions related to obesity care, reimbursement, and population health.

6. Conclusion

6.1 Summary of Value

The Obesity Management Strategy Summit provided a structured forum to synthesize emerging needs, identify practical barriers, and generate actionable strategies for integrating obesity management into sleep medicine. Through a combination of multidisciplinary input and implementation-focused prioritization, the summit clarified both the immediate opportunities and longer-term strategic directions for the field.

6.2 Call to Action

The findings of the summit support a clear call to action. Near-term efforts should focus on developing practical tools, educational resources, and workflow supports that enable clinicians to incorporate obesity-related care into practice. In parallel, longer-term initiatives should advance guideline development, strengthen partnerships,

and engage in advocacy to improve access and alignment across the healthcare system. Moving forward with intentionality, collaboration, and attention to patient-centered care will be essential to realizing the full potential of this evolving area.

7. Acknowledgments and Disclosures

7.1 Acknowledgments

The authors acknowledge the contributions of the American Academy of Sleep Medicine Obesity Management Task Force members, AASM leadership and staff, and the invited speakers, facilitators, and participants who contributed to the Obesity Management Strategy Summit. The summit benefited from the input of representatives from multiple professional societies, advocacy organizations, and clinical disciplines, whose perspectives enriched the discussion and informed the recommendations presented in this report.

7.2 AASM Obesity Management Task Force Disclosures

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