







Table of Contents

Message from the OMEC Steering Committee	3
Executive Summary	4
Supporting Organizations	6
OMEC Competencies	7
Educator Instructional Guide	10
Instructions for Assessment of Learners within a Training Program	11
Instructions for Assessment of Existing or Planned Curricula	12
Instructions for Assessment of Non-training Educational Environments	13
Sample Assessment Form (Exhibit A)	14
Obesity Medicine Competency Assessment	15

These materials were developed by and are jointly owned by the Obesity Medicine Association, The Obesity Society, and the American Society for Metabolic and Bariatric Surgery, collectively, the Obesity Medicine Education Collaborative ("OMEC"). OMEC encourages the use of these materials by medical schools and institutions to assist in the development of a clinician workforce that is competent and knowledgeable in the prevention and treatment of obesity. OMEC grants medical schools and institutions permission to use this document for educational and noncommercial purposes as a tool to evaluate students in these various obesity medicine competencies. Attribution to OMEC must be provided in all use of these materials. These materials may not be commercialized or adapted into derivative works. Any use of these materials for any other purpose other than educational and noncommercial purposes or any purpose that is unlawful or otherwise violates the permissions granted herein is strictly prohibited.

Message from the OMEC Steering Committee

A major challenge facing medical educators today is adequately training current and future physicians, nurse practitioners, and physician assistants in the prevention and treatment of obesity. However, the educational response to this escalating problem during undergraduate medical education (UGME) and graduate medical education (GME) has been limited due to the shortage of qualified faculty members who are trained in the science and practice of obesity medicine; limited time in a crowded curriculum; and lack of recognition of obesity by a primary or specialty board.

Nonetheless, it is paramount to develop a competent and knowledgeable clinician workforce that can provide adequate care to the 38% of U.S. adults and 17% of U.S. children and adolescents who have obesity.

One path toward reaching this goal is the development of comprehensive obesity-focused competencies. The rationale for this approach is three-fold:

- Medical training is competency-based.
- It is acknowledged that assessment drives learning.
- Having a comprehensive set of readily available curated competencies will facilitate widespread usage.

To this end, the Obesity Medicine Education Collaborative (OMEC) has developed the first set of obesityrelated competencies based on the Six Core Domain Competencies of the Accreditation Council for Graduate Medical Education (ACGME) that can be used in UGME and GME training programs.

The competencies were deliberately developed for learners at multiple stages of training and among different disciplines, since all trainees must be sufficiently qualified to care for patients with obesity. Additionally, since most medical, nursing, and PA curricula are now competency-based, the competencies were designed to be seamlessly utilized within the training assessment framework. Depending on the particular competency, measurement benchmarks that assess knowledge, skills, behavior, and attitudes are included to facilitate evaluator ratings. Similar to competencies in other fields of practice, they can be used for both formative and summative assessments.

For more information, please visit obesitymedicine.org/OMEC or email omec@obesitymedicine.org.

On behalf of OMEC, it is our hope that routine and more robust assessment of learners will increase their competence to prevent and treat obesity.

In good health,

Robert Kushner, MD, MS, FACP, FTOS, The Obesity Society Deborah Bade Horn, DO, MPH, MFOMA, Obesity Medicine Association W. Scott Butsch, MD, MSc, FTOS, The Obesity Society

Executive Summary

The Obesity Medicine Education Collaborative (OMEC) is an intersociety initiative that was formed in March 2016 and spearheaded by the Obesity Medicine Association (OMA), The Obesity Society (TOS), and the American Society for Metabolic and Bariatric Surgery (ASMBS). The mission of OMEC is to promote and disseminate comprehensive obesity medicine education across the continuum spanning undergraduate medical education (UGME), graduate medical education (GME), and fellowship training.

This executive summary reviews the methods and processes undertaken by the Collaborative to develop obesity medicine educational competencies¹.

A steering committee comprised of OMA, TOS, and ASMBS members² was joined by representatives from 12 additional professional societies and organizations³ to form working groups. Using the Six Core Domain Competencies⁴ of the Accreditation Council for Graduate Medical Education (ACGME) as a guiding framework, working group members collaborated by in-person meetings, email exchange, and conference calls between August 2016 and September 2017 to develop 32 obesity-related competencies with specific measurement and assessment benchmarks. The draft competencies, along with a vetting survey, were subsequently sent out for external review in October 2017 to 17 professional societies and organizations⁵. Results of the review were sent back to the working groups to revise the competencies based on comments.

A final document of 32 obesity-related competencies and associated benchmarks was completed in April 2018. The competencies are intended to be used by medical, nursing, and PA educators.

The 6 Core Domains and number of competencies are as follows:								
Patient Care and Procedural Skills	5							
✓ Medical Knowledge	13							
Practice-Based Learning and Improvement	5							
Interpersonal and Communication Skills	3							
✓ Professionalism	2							
System-Based Practice	4							

¹ Competency is an observational ability of a health professional, integrating multiple components such as knowledge, skill, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure acquisition.

² Kushner RF, Horn D, Butsch S, Pennings N, Lazarus E, Morton J, Brethauer S, Matter S, Apovian C.

³ American Association of Clinical Endocrinologists (AACE), American Congress of Obstetricians and Gynecologists (ACOG), American Association of Nurse Practitioners (AANP), American Academy of PAs (AAPA), American College of Lifestyle Medicine (ACLM), American College of Preventive Medicine (ACPM), American Osteopathic Association (AOA), Association of Colleges of Osteopathic Medicine (AACOM), American Society of Nutrition (ASN), Endocrine Society (ES), Society of Behavioral Medicine (SBM), Society of General Internal Medicine (SGIM).

⁴ Six Domain Competency framework: Practice-based Learning & Improvement, Patient Care and Procedural Skills, Systems-Based Practice, Medical Knowledge, Interpersonal and Communication Skills, and Professionalism

⁵ American Society of Addiction Medicine (ASAM), American College of Preventative Medicine (ACPM), American Gastroenterological Association (AGA), Society of General Internal Medicine (SGIM), American Congress of Obstetricians and Gynecologists (ACOG), American Academy of Sleep Medicine (AASM), Academy of Nutrition and Dietetics (AND), American College of Physicians (ACP), American Medical Association (AMA), American Academy of Pediatrics (AAP), Endocrine Society (ES), American Academy of Family Physicians (AAFP), American Association of Clinical Endocrinologists (AACE), American Academy of PAs (AAPA), Association of American Medical Colleges (AAMC), American Heart Association (AHA), American Medical Women's Association (AMWA).

Special thanks to the working group members, who dedicated their time and expertise to developing the 32 obesity medicine competencies:

- Robert Kushner. MD. MS. FACP. FTOS. The Obesity Society
- Deborah Bade Horn, DO, MPH, MFOMA, Obesity Medicine Association
- W. Scott Butsch, MD, MSc, FTOS, The Obesity Society
- Caroline Apovian, MD, FACP, FACN, FTOS, The Obesity Society
- Jamy Ard, MD, FTOS, The Obesity Society
- Sarah Armstrong, MD, American Academy of Pediatrics
- Daniel Bessesen, MD, FTOS, Endocrine Society
- Stacy Brethauer, MD, FASMBS, American Society for Metabolic and Bariatric Surgery
- Joshua Brown, PhD, FTOS, The Obesity Society
- John Cleek, MD, The Obesity Society and Obesity Medicine Association
- Mark DeFrancesco, MD, American Congress of Obstetricians and Gynecologists
- Katherine Duncan, MD, Fellow Representative
- Colony Fugate, DO, The Obesity Society and Obesity Medicine Association
- Angela Golden, DNP, FNP-C, FAANP, American Association of Nurse Practitioners
- Sherri Sheinfeld Gorin, PhD, Society of Behavioral Medicine
- · Carol Gorney, MPAS, PA-C, American Academy of PAs
- Eduardo Grunvald, MD, FACP, The Obesity Society and Obesity Medicine Association
- Adarsh K. Gupta, DO, MS, FACOFP, American Osteopathic Association
- George Guthrie, MD, MPH, American College of Lifestyle Medicine
- Leon I. Igel, MD, FACP, FTOS, Society of General Internal Medicine
- Madeline Joseph, MD, FAAP, FACEP, Obesity Medicine Association
- Scott Kahan, MD, MPH, FTOS, American College of Preventive Medicine and The Obesity Society
- Rekha Kumar, MD, The Obesity Society
- Ethan Lazarus, MD, FOMA, Obesity Medicine Association
- Samer Mattar, MD, American Society for Metabolic and Bariatric Surgery
- Janet McGill, MD, American Association of Clinical Endocrinologists
- · John Morton, MD, MPH, FTOS, American Society for Metabolic and Bariatric Surgery
- Connie Newman, MD, FACP, FAHA, FAMWA, The Obesity Society and American Medical Women's Association
- Judith Ockene, PhD, MA, MEd, Society of Behavioral Medicine
- Sherry Pagoto, PhD, Society of Behavioral Medicine
- Magdalena Pasarica, MD, PhD, The Obesity Society
- Nicholas Pennings, DO, FOMA, Obesity Medicine Association
- Heidi Silver, PhD, American Society of Nutrition
- Taraneh Soleymani, MD, FTOS, The Obesity Society
- Chris Still, DO, FACP, FTOS, The Obesity Society
- Virginia E. Uhley, PhD, RDN, The Obesity Society
- Amanda Velazquez, MD, FTOS, Resident Representative
- Pankaj Vij, MD, FACP, American College of Lifestyle Medicine
- Megan Winters, Medical Student Representative
- Adrienne Youdim, MD, FACP, The Obesity Society

Supporting Organizations

The following organizations have lent their support through endorsement of the OMEC competencies.

The Obesity Society (TOS)

Obesity Medicine Association (OMA)

American Society of Metabolic and Bariatric Surgery (ASMBS)

Academy of Nutrition and Dietetics (AND)

American Academy of PAs (AAPA)

American Association of Clinical Endocrinologists (AACE)

American Association of Nurse Practitioners (AANP)

American Board of Obesity Medicine (ABOM)

American College of Osteopathic Pediatricians (ACOP)

American College of Surgeons (ACS)

American Medical Women's Association (AMWA)

American Society for Gastrointestinal Endoscopy (ASGE)

Association for Bariatric Endoscopy (ABE)

Endocrine Society

Obesity Action Coalition (OAC)

Obesity Canada

Society of Behavioral Medicine (SBM)

Society of General Internal Medicine (SGIM)

Society of Teachers of Family Medicine (STFM)

World Obesity Federation (WOF)

OMEC Competencies

Below is a list of the 32 OMEC competencies by domain group.

PATIENT CARE AND PROCEDURAL SKILLS

5 COMPETENCIES

- Elicits comprehensive obesity-focused medical history.
- Performs and documents a comprehensive physical examination for the assessment of obesity.
- Effectively applies clinical reasoning skills when ordering and interpreting appropriate laboratory and diagnostic tests during the evaluation of patients with obesity.
- Utilizes evidence-based models of health behavior change to assess patients' readiness to change in order to effectively counsel patients for weight management.
- Engages the patients and their support systems in shared decision- making by incorporating their values and preferences in the development of a comprehensive personalized obesity management care plan.

MEDICAL KNOWLEDGE

13 COMPETENCIES

- Demonstrates knowledge of obesity epidemiology.
- Demonstrates knowledge of energy homeostasis and weight regulation.
- Demonstrates knowledge of anthropometric (body composition) measurements and clinical assessments of energy expenditure.
- Demonstrates knowledge of the etiologies, mechanisms, and biology of obesity.
- Demonstrates knowledge of obesity-related comorbidities and the corresponding benefits of body mass index (BMI) reduction.
- Applies knowledge of the principles of primary, secondary, and tertiary prevention of obesity to the development of a comprehensive, personalized obesity management care plan.
- Applies knowledge of obesity treatment guidelines to the development of a comprehensive, personalized obesity management care plan.
- Applies knowledge of using nutrition interventions to develop a comprehensive, personalized obesity management care plan.
- Applies knowledge of using physical activity interventions to develop a comprehensive, personalized obesity management care plan.
- Applies knowledge of using behavioral interventions to develop a comprehensive, 10 personalized obesity management care plan.
- Applies knowledge of using pharmacological treatments of obesity as part of a comprehensive, 11 personalized obesity management care plan.
- Applies knowledge of the surgical treatments of obesity as part of a comprehensive, personalized 12 obesity management care plan.
- Applies knowledge of emerging treatment modalities for obesity to the development of a comprehensive, personalized obesity management care plan.









PRACTICE-BASED LEARNING AND IMPROVEMENT **5 COMPETENCIES**



- Evaluates strengths and deficiencies in knowledge of obesity medicine, and sets and achieves goals for improvement.
- Analyzes practice systems using quality improvement methods to monitor and optimize obesity care.
- Utilizes resources to locate, interpret, and apply evidence from scientific studies regarding obesity treatment and its co-morbidities.
- Uses information technology related to obesity treatment to optimize delivery of care including electronic health records, software applications, and related devices (i.e., accelerometers, resting metabolic rate and body composition analysis technology).
- Effectively educates patients, students, residents, and other health professionals on the disease of obesity.

INTERPERSONAL AND COMMUNICATION SKILLS **3 COMPETENCIES**



- Uses appropriate language in verbal, nonverbal, and written communication that is non-biased, non-judgmental, respectful, and empathetic when communicating with patients with obesity.
- Uses appropriate language in verbal, nonverbal, and written communication that is non-biased, non-judgmental, respectful, and empathetic when communicating about patients with obesity with colleagues within one's profession and other members of the healthcare team.
- Demonstrates awareness of different cultural views regarding perceptions of desired weight and preferred body shape when communicating with the patient, family, and other members of the healthcare team.



PROFESSIONALISM

2 COMPETENCIES



- Demonstrates ethical behavior and integrity when counseling patients and their families who are living with overweight or obesity.
- Displays compassion and respect toward all patients and families who are living with overweight or obesity.

SYSTEMS-BASED PRACTICE

4 COMPETENCIES



- Works collaboratively within an interdisciplinary team dedicated to obesity prevention and treatment strategies.
- Advocates for policies that are respectful and free of weight bias.
- Utilizes chronic disease treatment and prevention models to advance obesity intervention and prevention efforts within the clinical, community, and public policy domains.
- Describes the costs of obesity intervention and prevention with regards to the individual, health care system, and community.



Educator Instructional Guide

EASY STEPS TO USING THE OMEC COMPETENCIES

The Obesity Medicine Education Collaborative (OMEC) was created to support training programs in the implementation of the obesity competencies, as well as to provide reliable assessment of performance of the competencies. The goal is to promote, disseminate, and improve comprehensive obesity medicine education across the continuum of medical education programs for physicians, nurse practitioners, and PAs.

The OMEC competencies were designed using the existing six ACGME domains. Within the six domains, there are 32 obesity-related competencies with specific measurement and assessment benchmarks to facilitate performance assessment.

The competencies can be applied to:

- Formative or summative assessment of learners within a training program
- 2 Assessment of existing or planned curricula
- 3 Assessment of non-training educational environments

?

For questions regarding the implementation or use of the OMEC competencies at your program, institution, society, or company, please contact **omec@obesitymedicine.org** to be connected with one of the steering committee members or an OMEC ambassador in your region.



Instructions for Assessment of Learners Within a Training Program

Choose the competencies to be evaluated.	
Full or Partial Evaluation - Select from 6 Domains and 32 Competencies Appropriate for formative or summative evaluation during training at the start, midpoint, and completion of a rotation, training year, or full training program. Selected Domain Evaluation	
Appropriate for shorter assignments, such as a journal club, M&M, or quality improvement project. These assignments may only cover a few competencies given limited time or limited focus.	

Choose a Likert scale, either 1-5 or 1-9.

Check with your institution or department to determine which scale has been chosen for consistency across learners.

Determine an acceptable benchmark score for your learner population.

In the sample assessment form (Exhibit A), a blue bar has been placed below the Likert scales as an example. Consider your group of learners (medical students, nurse practitioner students, PA students, residents, or fellows). The "acceptable" benchmark goal will change for different levels of learners and is set by your program or rotation. See Exhibit A on page 14.

Score the learner by scanning the five benchmark descriptions for the competency being evaluated and selecting an appropriate score.

Identify the method of assessment.

This could be direct observation, journal club presentations, chart review, or another method of assessment.

Provide supporting details.

Positive observations: Give the learner specific examples in which he or she excelled. Suggestions for improvement: Provide learners with areas to refocus.

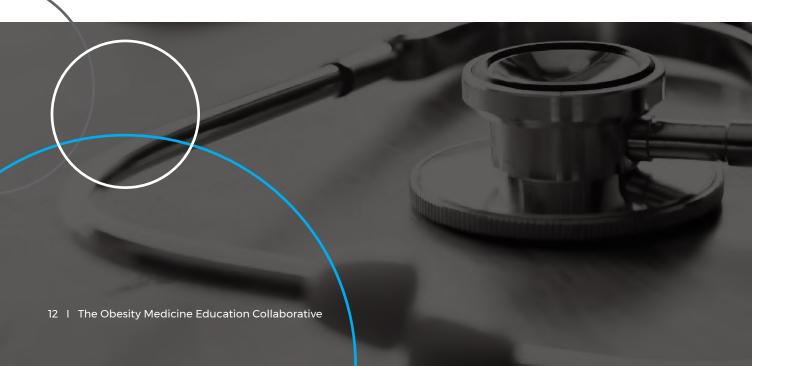
Note: Some competencies have suggested metrics or examples in the "Notes" box to help the evaluator be more objective in the score.

Consider a self-assessment by the learner at the start of the evaluation period and repeat the self-assessment at the end of evaluation period.

Instructions for Assessment of Existing or Planned Curricula

Choose the educational content to be evaluated. This could be a curriculum or CME offerings by the institution or entity.

Eva	luation:
	Evaluate using all 6 domains and 32 competencies.
	Use OMEC as a framework to map the current content.
	Identify the domains and competencies successfully addressed.
	Identify gaps for improvement based on competencies or entire domains that are minimal or absent in the current content.
lmp	provement:
	Identify topics or opportunities that can be added or adjusted to address competency gaps noted above.
	Use the OMEC map of your program to plan for improvement in future educational choices.



Instructions for Assessment of Non-Training Educational Environments

The OMEC competencies can provide a road map for education of individuals, companies, institutions, and societies that work or operate closely with medical prescribers in the field of obesity medicine. Not all six domains apply in these scenarios; for example, many patient care competencies would not apply to non-medical providers.

However, many of the competencies around professionalism, medical knowledge, interpersonal and communication skills, system-based practice, and practice improvement can be applied in a variety of environments that relate to obesity.

Example #1: A hospital system can identify competencies to focus and drive staff training around the care of patients with obesity.

Example #2: An industry partner that provides an obesity-related product or service - such as a medication or surgical device for the treatment of obesity - can choose competencies to incorporate into employee training in an effort to better understand the field and the healthcare providers with whom they interact.



SAMPLE ASSESSMENT FORM (EXHIBIT A)

See page 14 for the sample assessment form.

Consider your group of learners (medical students, nurse practitioner students, PA students, residents, fellows, or other learners) and determine an acceptable benchmark score for your learner population. The "acceptable" benchmark goal will change for different learner levels and is set by you and your program or rotation.

In the sample assessment form on the next page, a blue bar has been placed above the middle benchmark as an example of a benchmark or goal that a medical student, nurse practitioner student, or PA student might achieve as acceptable for their training level. The blue bar might be moved above the fourth benchmark for residents and above the fifth benchmark for a learner in a fellowship program.

OBESITY MEDICINE COMPETENCY ASSESSMENT SAMPLE FORM

Level of Education (UGME, GME, Fellowship) Competency Domain

INSTRUCTIONS: This evaluation should be based on observations of the Typicalare expected to achieve the benchmark level of competency (highlighted in blue) at this stage of their health professional careers. Occasionally, may be above or below the benchmark. Please also provide specific positive observations and suggestions for improvement.											
1	2	3	4	5	6	7	8	9			
1	2	<u> </u>		3			4	5			
Method of Assessme Reflections, Checklis	_				atient (Observation	n, Chart Re	view, Oral Exam,			
Positive Observation	ns:										
Suggestions for Imp	provement:										

NAME OF EVALUATOR POSITION

OBESITY MEDICINE

Competency Assessment



1 Competency: Elicits comprehensive obesity-focused medical history.

1	2	3	4 5 6		7	8	9		
1	2	2		3		4		5	
Complete history taking is insensitive, disorganized, and/ or misses important details for patients with simple weight management challenges.	Complete history talk is reasonal sensitive a uses people language, organized complete few importants for with simple management challengers.	king ably and ble-first is fairly I and , missing rtant r patients ble weight	taking family uses plangua organi complapro gather related and is patient simple	ized an lete, is priate f ring obe d inform efficier ets with e weigh gemen	nt and red, first d or esity- nation, nt for	Complete history ta is patient family-ce uses peop first languis organiz complete appropria for gather obesity-reinformatic is efficien patients of managen challenge	king and ntered, ole- uage, ed and r, is ate ring elated on, and t for with e weight nent	Complete history taking is patient and family-centered, uses people- first language, is organized and complete, is appropriate for gathering obesity-related information, and is efficient for patients with complex clinical and psychological weight manage- ment challenges.	

2 Competency: Performs and documents a comprehensive physical examination for the assessment of obesity.

1	2	3	4	5	6	7	8	9
1	2	2		3		,	4	5
Physical examination is incomplete, techniques are inaccurate and insensitive to pa- tient's modesty and comfort during physical examination; incomplete documentation of findings.	Physical examinat contains I compone technique fairly appliand fairly to patient modesty comfort ophysical examinat fairly comdocumen of finding	key Ints; es are ropriate sensitive 's and during ion; uplete tation	usually and for technic mostly usually patien and code examined examined for the control of find mostly and or patient simple.	nation y comp ocused, ique is y accura y ensur t's mod omfort g physic nation; mentati lings ar y comp rganize ots with e weigh	ate, es esty cal on e lete d for	Physical examinatis consiste complete systematiand focus appropriation using acceptant that ensure patient's and complete well organ for patient moderate managen challenge	ently e, ic, sed ately urate es re modesty fort; atation as is and anized ats with e weight ment	Physical examination is consistently complete, systematic, and focused appropriately using accurate techniques that ensure patient's modesty and comfort; docu- mentation of findings is complete and well organized for patients with complex weight management challenges.

3 Competency: Effectively applies clinical reasoning skills when ordering and interpreting appropriate laboratory and diagnostic tests during the evaluation of patients with obesity.

1	2	3	4	5	6	7	8	9
1	2	2		3		4		5
Use of evidence-based laboratory and diagnostics tests is incomplete or disorganized, orders unnecessary or non-evidence-based tests, clinical reasoning and interpretation of data is limited, and differential diagnosis is limited or not supported.	Use of lab and diagr tests is or clinical re and interp are missir key comp but differe diagnosis supported	nostic ganized, asoning pretation ng a few conents ential is	and di tests is clinical and in of data different diagno included	osis and le the osis for e cases	ic ized, ning ation ort	Use of lab and diagr tests is or and effici without extraneou diagnosti moderate challengin of obesity reasoning interpreta of data ar accurate support t correct di	nostic ganized ent us cs for ely ng cases y, clinical g and ation re and	Use of laboratory and diagnostic tests is organized and efficient without extraneous diagnostics in complex cases of obesity, clinical reasoning and interpretation of data are accurate and support the correct diagnosis.

4 Competency: Utilizes evidence-based models of health behavior change to assess patients' readiness to change in order to effectively counsel patients for weight management.

1	2	3	4	5	6	7	8	9
1	2	2		3		4		5
Counseling for weight management is performed, but evidence-based models of health behavior change are not used. The goals are incomplete and provider-centered.	Counseling weight man ment is so performed evidence models of behavior of Goals programmed thorough, patient-confor patient simple were manager challenger	anage- ometimes d using based f health change. vided are es clear, and entered ts with eight nent	weigh ment perfor evider mode behav Goals clear, t and par center Couns usually for par simple	red. eling is y efficie tients v e weigh gemen	ige- illy sing sed alth nge. ed are gh,	Counselir weight m ment is consistent of patients weight models of performe evidence models of behavior Goals proceder, thou and patiencentered. Counselir consistent of patients weight moderate managen challenge	eanage- consistently d using based f health change. vided are rough, ent- ag is tly for with e weight nent	Counseling for weight management is consistently performed using evidence-based models of health behavior change. Goals provided are clear, thorough, and patient-centered. Counseling is consistently efficient for patients with complex weight management challenges.

5 Competency: Engages the patients and their support systems in shared decision-making by incorporating their values and preferences in the development of a comprehensive personalized obesity management care plan.

1	2	3	4	5	6	7	8	9
1	2	2		3			4	5
Patients and their support systems are rarely engaged in shared decision-making, and the management plan is non-personalized for patients with simple weight management challenges.	Patients a support stare somethen engaged decision-reto develop personalizing sity manaplan for personalizing managements.	ystems cimes in shared making o a fairly zed obe- gement atients le weight	their s system usually shared making a com persor obesit ment patient simple	y engag d decisi g to de prehen alized y mana plan fo its with e weigh gemen	ged in on- evelop asive age- r	Patients a support s are consistent adecision-develop a compreh personali obesity magement for patien moderate managen challenge	ystems stently in shared making to ensive zed nan- plan ots with e weight nent	Patients and their support systems are consistently engaged in shared decision-making to develop a comprehensive personalized obesity management plan for patients with complex weight management challenges.

1 Competency: Demonstrates knowledge of obesity epidemiology.

1	2	3	4	5	6	7	8	9
1	2			3			4	5
Lacks basic knowledge of overweight and obesity incidence and prevalence, effects on morbidity and mortality, and demographic associations and distributions for children and adults. Cannot identify common environmental, socioeconomic, and behavioral contributors to the obesity epidemic at the population level.	Has basic knowledge overweigh obesity in and prevalence of morbidity mortality, demograph association distribution children and adults. Calidentify contribute obesity exat the poplevel.	nt and cidence alence, and and ohic ans for and ommon ental, nomic, vioral ors to the oidemic	knowled overwork obesit preval trends morbi mortal demo associ distribution of the comment of the comment of the comment of the comment of the contribution obesit of the contribution of	dults. Instrate edge o	nd ence, nd es on d d and es and es f al, nic, ral to the	Has above average knowledge overweigh obesity in prevalence trends, eff morbidity, demogra association distribution for childre and adult Demonst knowledge common the environs socioecor and behalf contribution obesity en at the populevel.	ge of ht and ncidence, ce, and fects on / and , and phic ons and ons en cs. rates ge of and sub- nmental, nomic, vioral ors to the pidemic	Has exceptional knowledge of overweight and obesity incidence, prevalence, and trends, effects on morbidity and mortality, and demographic associations and distributions for children and adults. Demonstrates knowledge of common, subtle, and theorized environmental, socioeconomic, and behavioral contributors to the obesity epidemic at the population level.

2 Competency: Demonstrates knowledge of energy homeostasis and weight regulation.

1	2	3	4	5	6	7	8	9
1	2	2		3		,	4	5
Lacks basic knowledge of energy homeostasis and weight regulation, including cellular and biochemical energy storage/ transfer, thermodynamics, and energy expenditure.	Has basic knowledge of energy homeostal weight resincluding and biochenergy stotransfer, the namics, as energy expenditure.	ge asis and gulation, cellular nemical orage/ hermody- nd	weigh and ca that ki	edge rgy ostasis t regula an appl nowled clinical	ation, y ge	knowledg of energy homeosta weight re including	asis and gulation, euroendo- siology, apply vledge nical care	Has exceptional knowledge of energy homeostasis and weight regulation, including enteroneuroendocrine physiology, and can apply that knowledge to the clinical care of complex patients.

3 Competency: Demonstrates knowledge of anthropometric (body composition) measurements* and clinical assessments of energy expenditure.

1	2	3	4	5	6	7	8	9
1	-	2		3		4		5
Lacks basic knowledge of body composition measurements and clinical assessments of energy expenditure (e.g., Harris- Benedict (HB) and Mifflin-St. Jeor (MSJ) equations).	Has basic knowledg body com measurer and clinic assessme energy ex (e.g., HB a equations	ge of nposition ments al nts of penditure nd MSJ	knowl body of measu (include bioim skinfo ments assess energy (e.g., Hequat can ap knowl	pedand ld mea s) and c sments y expen IB and ions), a oply tha ledge to inical ca	sition ats ce, sure- clinical of aditure MSJ ad	composit measurer (including bioimpec skinfold r ments, D	ge of body ion ments dance, measure- XA) and sessments expendi- HB and ations, alorime- can apply vledge nical atients. es ns, as, and various	Has exceptional knowledge of body composition measurements (including bioimpedance, skinfold measurements, DXA, crosssectional imaging, underwater weighing) and clinical assessments of energy expenditure (e.g., HB and MSJ equations, indirect calorimetry, doubly-labeled water, metabolic chamber), and can apply that knowledge to the clinical care of complex patients. Can distinguish nuanced differences between various technologies and measurements, and is able to apply the appropriate study for clinical or investigational purposes.

^{*}Body composition measurements may include weight for length, BMI, BMI percentile, BMI z-score, BMI % relative to 95th percentile, waist circumference (WC), and waist-to-hip ratio (WHR).

4 Competency: Demonstrates knowledge of the etiologies, mechanisms and biology of obesity.

1	2	3	4	4 5 6		7	8	9	
1	2	2	3				4	5	
Lacks basic knowledge of the etiologies, mechanisms, and biology of obesity.	Has basic knowledg the etiolo mechanis biology of	gies, ms, and	the eti mecha and bi obesit apply knowl	edge o lologies anisms, ology o y, and o that edge to nical ca	s, , of can	Has above average knowledge the etiology mechanism and biology obesity, a can apply knowledge the clinic of patients	ge of ogies, sms, ogy of and that ge to al care	Has comprehensive knowledge of the etiologies, mechanisms, and biology of obesity, and can apply that knowledge to the clinical care of complex patients.	

5 Competency: Demonstrates knowledge of obesity-related comorbidities and the corresponding benefits of body mass index (BMI) reduction.

1	2	3	4	5	6	7	8	9
1	2	2	3			4		5
Lacks basic knowledge of obesity-related comorbidities and the corresponding benefits of BMI reduction.	Has basic knowledge obesity-re- comorbid the correst benefits of reduction	elated lities and sponding of BMI	knowl obesit comor the co benefit reduct can ap knowl	verage edge of y-relate rbidities rrespor its of Bi tion, an oply that edge to nical cal ients.	ed s and nding MI d at	Has above average knowledge obesity-recomorbic the correst benefits or reduction can apply knowledge the clinical of patients	ge of elated dities and sponding of BMI n, and that ge to al care	Has exceptional knowledge of obesity-related comorbidities and the corresponding benefits of BMI reduction, and can apply that knowledge to the clinical care of complex patients.

6 Competency: Applies knowledge of the principles of primary, secondary, and tertiary prevention of obesity to the development of a comprehensive, personalized obesity management care plan.*

1	2	3	4	5	6	7	8	9
1	2	2	3			4		5
Lacks basic knowledge of the principles of primary, secondary, and tertiary prevention for the prevention and treatment of obesity.	Has basic knowledge the princi- of primary secondary tertiary pri for the pro- and treati- obesity.	ge of ples y, y, and revention evention	the proof printer second tertiar for the and troof obe can appear to the can appear	edge o inciples nary, dary, ar y preve e preve eatmer sity, an oply tha edge to nical ca	nd ention ention ent d at	Has above average knowledge the principal of primary secondary tertiary principal for the principal of obesity can apply knowledge the clinical of patients	ge of iples y, y, and revention evention ment y, and that ge to al care	Has exceptional knowledge of the principles of primary, secondary, and tertiary prevention for the prevention and treatment of obesity, and can apply that knowledge to the clinical care of complex patients.

^{*}Definitions in the context of obesity. Primary prevention: prevent development of overweight/obesity. Secondary prevention: reduce BMI to prevent development of weight-related complications. Tertiary prevention: reduce BMI to prevent progression or worsening of established weight-related complications.

7 Competency: Applies knowledge of obesity treatment guidelines to the development of a comprehensive, personalized obesity management care plan.

1	2	3	4	5	6	7	8	9
1	2	2	3		4		5	
Lacks basic knowledge of guidelines for the treatment of obesity.	Has basic knowledg of guidelin for the tre of obesity	nes atment	knowl guidel the tre of obe can ap knowl	verage edge of lines for leatmen esity, an oply the edge to nical calients.	t d at	Has above average kill of guidelithe treatr of obesity can apply knowledge the clinical of patient Recogniz limitation guideline respect to individual patient can above the clinical can apply the clinical can apply knowledge the clinical can be above to the company of the com	nowledge nes for ment v, and v that ge to al care cs. es s of s with	Has exceptional knowledge of guidelines for the treatment of obesity, and can apply that knowledge to the clinical care of complex patients. Recognizes the evidence base for obesity treatment guidelines, limitations of guidelines with respect to individual patient care, and areas of continued scientific uncertainty.

8 Competency: Applies knowledge of using nutrition interventions to develop a comprehensive, personalized obesity management care plan.

1	2	3	4	4 5 6		7	8	9
1	2	2	3			4		5
Lacks basic knowledge of nutrition interventions for the treatment of obesity.	Has basic knowledg of nutritio interventi for the tre of obesity	n ons eatment	for the of obe can ap knowl	edge rition entions e treatn esity, an oply the edge to nical ca	nent d at	Has above average knowledge of nutrition intervention of obesity can apply knowledge the clinic of patients	ge on ions eatment /, and / that ge to al care	Has exceptional knowledge of nutrition interventions for the treatment of obesity, and can apply that knowledge to the clinical care of complex patients.

9 Competency: Applies knowledge of using physical activity interventions to develop a comprehensive, personalized obesity management care plan.

1	2	3	4	5	6	7	8	9	
1	2	2	3			4		5	
Lacks basic knowledge of physical activity guidelines and interventions for the treatment of obesity.	Has basic knowledg physical a guidelines intervention the treatm obesity.	ctivity s and ons for	physic guidel interve the tre of obe can ap knowl	edge of all activities and entions eatmen sity, and edge to nical cal	ity d for t d ut	Has above average knowledge physical a guideline intervention the treatr of obesity can apply knowledge the clinical of patient	ge of activity s and ions for ment r, and that ge to al care	Has exceptional knowledge of physical activity guidelines and interventions for the treatment of obesity, and can apply that knowledge to the clinical care of complex patients.	

10 Competency: Applies knowledge of using behavioral interventions to develop a comprehensive, personalized obesity management care plan.

1	2	3	4	5	6	7	8	9
1	2	2	3			4		5
Lacks basic knowledge of behavioral interventions for the treatment of obesity.	Has basic knowledg behaviora interventi for the tre of obesity	ons eatment	interve the tre of obe can ap knowl	edge navioral entions eatmen esity, an oply the edge to nical ca	for t d at	Has above average knowledge behavioral intervention of obesity can apply knowledge the clinical of patients.	ge of al ions eatment , and that ge to al care	Has exceptional knowledge of behavioral interventions for the treatment of obesity, and can apply that knowledge to the clinical care of complex patients.

^{*}e.g., behavior therapy strategies, psychological counseling, sleep regulation, stress reduction

11 Competency: Applies knowledge of using pharmacological treatments of obesity as part of a comprehensive, personalized obesity management care plan.

1	2	3	4	5	6	7	8	9
1	2	2	3			4		5
Does not recognize anti- obesity medication as an appropriate form of therapy. Lacks basic knowledge of the age-appropriate pharmacothera- peutic options for the treatment of obesity, including their indications, contraindications, side effects, and mechanisms of action.	Recognize ti-obesity cation as propriate therapy, a basic kno the age-a ate pharn apeutic o the treatr obesity, ir their indic contraind side effec mechanis of action.	medi- an ap- form of nd has wledge of ppropri- nacother- ptions for nent of ncluding cations, ications, ts, and	age-appharm peutice the tree obesite their in contra- side et mecha- of acti- can app knowl	edge of oproprion acother option by, including the fects, and on, and oply the edge to nical callocal	ate era- is for it of ding ons, cions, and	Has above knowledge age-approphermace peutic op the treatrobesity, in their indiction, and apply that knowledge the clinical of patients.	opriate othera- otions for ment of ncluding cations, lications, ets, and sms of nd can t ge to al care	Has exceptional knowledge of the age-appropriate pharmacotherapeutic options for the treatment of obesity, including their indications, contraindications, side effects, and mechanisms of action, and can apply that knowledge to the clinical care of complex patients.

12 Competency: Applies knowledge of the surgical treatments of obesity as part of a comprehensive, personalized obesity management care plan.

1	2	3	4	5	6	7	8	9
1	2	2	3		4		5	
Does not recognize bariatric surgery as an appropriate form of therapy or the options available. Lacks basic knowledge of the mechanisms of action and metabolic/clinical outcomes.	Recognize age-appropriate as an appropriate of available. basic known the mechal of action a metabolic outcomes	opriate surgery ropriate nerapy ptions Has wledge of anisms and	surgication for the of obe mechal of action metals outcome can appear to the control of the can appear to the can appear	edge o al optic e treatn esity, anisms on, and oolic/cli mes, ar oply the edge to nical ca	ons nent d nical nd at	knowledge surgical of for the tree of obesity anisms of and meta clinical or	eptions eatment , mech- action, abolic/ utcomes, apply that ge to the post- clinical	Has exceptional knowledge of the evidence-based patient selection for surgical options for the treatment of obesity, mechanisms of action, and metabolic/clinical outcomes, and can apply that knowledge to the pre- and post-operative clinical care of complex patients.

13 Competency: Applies knowledge of emerging treatment modalities for obesity to the development of a comprehensive, personalized obesity management care plan.

1	2	3	4	5	6	7	8	9	
1	2	2	3			4 5			
Lacks basic knowledge of emerging modalities for the treatment of obesity.	Has basic knowledg of emergi modalitie for the tre of obesity	je ng s atment	of obe	edge erging lities e treatn esity, an oply the edge to nical ca	d at	Has above average knowledge of emerging modalities for the tree of obesity can apply knowledge the clinical of patients	ge ing es eatment /, and / that ge to al care	Has exceptional knowledge of emerging modalities for the treatment of obesity, and can apply that knowledge to the clinical care of complex patients.	

^{*}e.g., devices, medications, procedures/surgeries, endoscopic bariatric therapies (EBTs), electronic applications/technologies

COMPETENCY DOMAIN: PRACTICE-BASED LEARNING AND IMPROVEMENT (5 COMPETENCIES)

1 Competency: Evaluates strengths and deficiencies in knowledge of obesity medicine and sets and achieves goals for improvement.

1	2	3	4	5	6	7	8	9
1	2	2	3		4		5	
Unable to evaluate strengths and deficiencies in knowledge of obesity medicine, and unable to set goals for improvement.	Able to ever few streng and deficition in knowled obesity mand able to and achied limited good improvements.	gths dencies dge of edicine, to set ve	some and de in kno obesity and ak achiev	o evalustrengt eficience wledge y medic ole to se e some provem	chs cies e of cine, et and goals	Able to ever most stree and defice in knowled obesity mand able and achies most goal improven	ngths iencies edge of nedicine, to set eve	Able to comprehensively evaluate strengths and deficiencies in knowledge of obesity medicine, and able to consistently set and achieve goals for improvement.

COMPETENCY DOMAIN: PRACTICE-BASED LEARNING AND IMPROVEMENT (5 COMPETENCIES)

2 Competency: Analyzes practice systems using quality improvement methods to monitor and optimize obesity care.

1	2	3	4	5	6	7	8	9
1	2		3			4		5
Unable to analyze practice systems using quality improvement methods to monitor and optimize obesity care.	Able to analyze some practice systems using quality improvement methods to monitor and optimize obesity care.		Able to analyze a wide range of basic practice systems using quality improve- ment methods to monitor and optimize obesity care.			Able to analyze more advanced practice systems using quality improvement methods to monitor and optimize obesity care.		Consistently able to analyze complex practice systems using quality improve- ment methods to monitor and optimize obesity care.

COMPETENCY DOMAIN: PRACTICE-BASED LEARNING AND IMPROVEMENT (5 COMPETENCIES)

3 Competency: Utilizes resources to locate, interpret, and apply evidence from scientific studies regarding obesity treatment and its co-morbidities.

1	2	3	4	5	6	7	8	9
1	2		3			4		5
Unable to utilize resources to locate, interpret, or apply evidence from scientific studies regarding obesity treatment and its co-morbidities.	Able to utilize resources to locate evidence, but unable to interpret or apply evidence from scientific studies regarding obesity treatment and its co-morbidities.		Able to utilize resources to locate evidence and beginning to interpret, but not able to apply evidence from scientific studies regarding obesity treatment and its co-morbidities.			Able to utilize resources to locate and interpret evidence, and begins to apply evidence from scientific studies regarding obesity treatment and its co-morbidities.		Consistently utilizes resources to locate, interpret, and apply evidence from scientific studies regarding obesity treatment and its co-morbidities.

COMPETENCY DOMAIN: PRACTICE-BASED LEARNING AND IMPROVEMENT (5 COMPETENCIES)

4 Competency: Uses information technology related to obesity treatment to optimize delivery of care including EHRs, software applications, and related devices (i.e., accelerometers, resting metabolic rate, and body composition analysis technology).

1	2	3	4	4 5 6		7 8		9
1	2	2		3		4		5
Unable to use any forms of information technology related to obesity treatment to optimize delivery of care including EHRs, software applications, and related devices.	Able to use few limited of informate technology to obesity treatment with an incomprehe and there unable to delivery of including software application related delivery delivery of including software application and the comprehence of the com	ed forms ation gy related c, but complete ension, fore optimize f care EHRs,	related obesit to opt deliver includ EHRs, applic	forms rmatio ology d to y treatr imize ry of ca	ment re re and	Able to us most form informati technology related to obesity to to optimic delivery of care inclusively EHRs, sof application	ns of on gy eatment ze of iding tware ons, and	Very proficient in the use of information technology related to obesity treatment to optimize delivery of care including EHRs, software applications, and related devices.

COMPETENCY DOMAIN: PRACTICE-BASED LEARNING AND IMPROVEMENT (5 COMPETENCIES)

5 Competency: Effectively educates patients, students, residents, and other health professionals on the disease of obesity.

1	2	3	4	4 5 6		7	8	9
1	2	2	3			4		5
Unable to educate patients, students, residents, and other health professionals on the disease of obesity.	Provides in or incompeducation patients, so residents, other heat profession on the distortion of obesity	olete n to students, and Ith nals sease	cation patien reside other profes on the of obe	les basi	d se basic	Effectively educates students, and other profession on the distriction of obesity common advanced clinical care	patients, residents, r health nals sease v in , more	Consistently and effectively educates patients, students, residents, and other health professionals on the disease of obesity in a full spectrum of scenarios, including challenging clinical cases.

COMPETENCY DOMAIN: INTERPERSONAL AND COMMUNICATION SKILLS (3 COMPETENCIES)

Competency: Uses appropriate language in verbal, nonverbal, and written communication that is non-biased, non-judgmental, respectful, and empathetic when communicating with patients with obesity.

1	2	3	4	4 5		7	8	9
1	2	2	3			,	4	5
Verbal, nonverbal, and written communication is biased, judgmental, disrespectful, and/ or not empathetic when communicat- ing with patients with obesity.	Occasiona utilizes ve nonverba written communi that is inapprope when end with patie obesity, b corrects v pointed o	rbal, I, and Ication riate gaging ents with ut vhen	verbal and w comm that is when	, ritten nunicat approp engagi patients	ion oriate ng	Consister utilizes ap verbal, no and writte commun that is tail to individ circumsta when end with patie obesity, ir challengin situations	opropriate onverbal, en ication lored ual ances gaging ents with neluding	Consistently and effortlessly utilizes appropriate verbal, nonverbal, and written communication that is clear, concise, and tailored to individual circumstances when engaging with patients with obesity in all situations.

^{*}Verbal – includes people-first and weight-friendly language

COMPETENCY DOMAIN: INTERPERSONAL AND COMMUNICATION SKILLS (3 COMPETENCIES)

2 Competency: Uses appropriate language in verbal¹, nonverbal, and written communication that is non-biased, non-judgmental, respectful, and empathetic when communicating about patients with obesity with colleagues within one's profession and other members of the healthcare team.

1	2	3	4	5	6	7	8	9
1	2	2		3			4	5
Verbal, nonverbal, and written communication is biased, judgmental, and/or disrespectful when communicating with healthcare professionals in clinical and non-clinical settings. ²	Occasiona utilizes ve nonverba and writte communi that is inappropri when eng healthcar profession in clinical non-clinical settings, but correct when poi	rbal, l, en cation riate gaging e nals and cal	verbal and w comm that is when health profes	rritten nunicat appropengagi engagi ncare ssionals ical and	ion oriate ng		opropriate onverbal, en ication lored ual ances gaging re nals and cal	Consistently and effortlessly utilizes appropriate verbal, nonverbal, and written communication that is clear, concise, and tailored to individual circumstances when engaging healthcare professionals in clinical and non-clinical settings and in all situations.

¹Verbal – includes people-first and weight-friendly language

²Non-clinical – includes discussions outside of patient care setting such as back office, hallways, cafeteria, or social settings

COMPETENCY DOMAIN: INTERPERSONAL AND COMMUNICATION SKILLS (3 COMPETENCIES)

3 Competency: Demonstrates awareness of different cultural views regarding perceptions of desired weight and preferred body shape when communicating with the patient, family, and other members of the healthcare team.

1	2	3	4	5	6	7	8	9
1	2	2	3			,	4	5
Exhibits specific episodes of cultural insensitivity when communicating with others. ¹	Exhibits la of apprect for cultural diversity apreference community with othe corrects we pointed of	iation al and es when cating rs, but	appreculturiand p when cating and m	enstrate ciation al diver referen comm with o nakes u erpreter es whe ted.	of esity ces uni- thers se	Consister demonstration and prefer when correcting wire consistent uses interservices windicated in challent situations addresses adversity or denial change. Recognizing implicit a explicit bit patients, staff, and	rates ciation I diversity erences mmuni- th others, tly ereter when and aging s, s to es and ias in family,	Consistently demonstrates an appreciation of cultural diversity and preferences when communicating with others in all situations, role models and teaches these qualities to other members of the healthcare team. Recognizes and addresses implicit and explicit bias in patients, family, staff, and self.

¹ Others = including patient, family and other members of the healthcare team

² Diversity and preferences = including language, ideal body weight and shape, family rituals, lifestyle practices, food choices, and/or use of alternative medicines

³ Adversity = including thorough exploration of cultural barriers or any additional comments

COMPETENCY DOMAIN: PROFESSIONALISM (2 COMPETENCIES)

1 Competency: Demonstrates ethical behavior and integrity when counseling patients and their families who are living with overweight or obesity.

1	2	3	4 5 6		7	8	9	
1	2	2	3			,	4	5
Exhibits lack of competence, honesty, responsibility, and/ or trustworthiness and exhibits bias when counseling patients and families who are living with overweight or obesity, and fails to acknowledge or correct when pointed out.	Exhibits la competer honesty, responsib trustwort and/or exi when counselin patients a families w living with overweigh obesity, b corrects w pointed or	ility, hiness, hibits bias g and ho are n t or ut	hones respon trustw and la when most i patien familie are livi	etence, ty, nsibility orthine ck of b counse f not al its and es who ing witl eight o	r, ess, ias eling I	Consister exhibits competer honesty, responsible trustwort and lack of when coupatients a families williving with overweigh obesity, ir in challen situations	nce, bility, hiness, of bias unseling and who are h ht or ncluding	Consistently exhibits competence, honesty, responsibility, trustworthiness, and lack of bias when counseling patients and families who are living with overweight or obesity in all situations, and acts as a role model to teach these qualities to others.

COMPETENCY DOMAIN: PROFESSIONALISM (2 COMPETENCIES)

2 Competency: Displays compassion and respect toward all patients and families who are living with overweight or obesity.

1	2	3	4	4 5 6		7 8		9	
1	2	2		3		4		5	
Exhibits lack of compassionate, respectful behavior and/or exhibits bias when working with patients and families who are living with overweight or obesity, and fails to acknowledge or correct when pointed out.	Exhibits la compassi respectful behavior a exhibits behavior a families which are living overweight obesity, becorrects where the pointed of the second of t	onate, I and ias when vith ind /ho with ont or ut	and rebehave of bias ing winot all families living vi	espectful ior and swhen th mos patien es who with ov t or obe	ul lack work- t if ts and are	Consister exhibits compassi and respective behavior of bias who working was patients a families ware living overweigh obesity, ir in challen situations	ionate ectful and lack nen with and who with ht or ncluding	Consistently exhibits compassionate and respectful behavior and lack of bias when working with patients and families who are living with over- weight or obesity in all situations, and acts as a role model to teach these qualities to others.	

1 Competency: Works collaboratively within an interdisciplinary team dedicated to obesity prevention and treatment strategies.

1	2	3	4 5 6		7	8	9	
1	7	2	3			4		5
Limited understanding of the role of the physician (both generalist and specialist), advanced practice providers, other allied health professionals, and community members, agencies, and policy makers in the prevention and treatment of obesity.	Able to de in detail, to of practic physician advanced providers allied heat profession but incomengages if fessional immembers a superficunderstar of the role various comembers cies, and immembers cies, and imprevention treatment obesity.	the scope e for s, I practice , and alth hals, sistently nterpro- team s. Has cial hding e of mmunity s, agen- policy the n and	in det. of pra- sicians practi and al profes well a variou memb and p play ir prever treatn obesit articu mech in whi interd teams togeth a com Active partic multic teams	ntion ai nent of cy. Clear lates anisms ch isciplin s work ner to a	scope or phy- nced viders, alth s, as oles nunity encies, akers nd cly ary chieve oal. n nary the	interdisciple team mento advance prevention intervention intervention communith Has a supunderstand policy-lev	iplinary mbers nical provide ensive eatments, s tively with plinary mbers te obesity n and on ty settings. perficial ending of rel change s, but may te in	Exemplifies leadership within both clinical and community settings. Effectively organizes medical- community collaboratives to design and implement obesity prevention and intervention initiatives and guide multidisciplinary teams to impact policy-level change.

2 Competency: Advocates for policies which are respectful and free of weight bias.

1	2	3	4	5	6	7	8	9
1	2			3			4	5
Knowledge of the professional literature and currently available resources regarding weight bias is limited.	Aware of profession literature currently resources ing weigh however, efforts to weight bit the clinical are limited.	and available regard- it bias; proactive reduce as within	for perdemo respectively seeks weigh the cli however of weight the control of the	nstratinetful pa proactive to reduct bias venical se ver, effore the efformune on the leader of the	ng itient vely ice vithin etting; orts to ffects s at ity	weight bi educate p actively e	as within al setting t; y utilizes ssional and available regarding as to beers; ngages fessionals	Effectively utilizes the professional literature and currently available resources regarding weight bias to advocate on behalf of his/her patients beyond the clinical setting. This may include educating community members and policy makers or lobbying to healthcare administrators/ payers for resources that improve patient outcomes and delivery of care or decrease potential for bias.

3 Competency: Utilizes chronic disease treatment and prevention models to advance obesity intervention and prevention efforts within the clinical, community, and public policy domains.

1	2	3	4	5	6	7	8	9
1	2			3			4	5
Has knowledge of chronic disease treatment and prevention models is superficial.	Able to de detail, the chronic di treatment prevention however, it ion within community public potings is limited.	various isease t and n models; applica- n clinical, ty, and licy set-	based clinical decision the individual overwork obesit engage with or obesit familial barries within ment care distinct care dis	s popul data to al pract on-mak care of duals w reight o y; activ es indiv es to re rs to he and he elivery ns; how oordina ficient a d to hea elivery us; applia comm ublic po ins is lir	o drive ice king ith rely iduals ght or heir duce ealth over, ation alth cation nunity olicy	Effectively efficiently coordinate comprehensive and communications and communications and communications are in bound and communications and communications are in bound and communications a	ees ensive, entered th clinical munity pplication e public	Actively advocates for public policy changes that reduce environmental barriers to health, reduce health care systems inefficiencies, improve health care accessibility for individuals with overweight or obesity, and reduce barriers to care coordination between the health care team and community agencies.

RELEVANT METRICS:

Clearly articulates the impact of health care delivery systems and accessibility, care coordination, environmental conditions, psychological wellbeing, and various systems of influence (e.g., interpersonal, community, policy) on health and health behaviors.

RELEVANT MODELS:

Social ecological model | Social determinants of health | Chronic care model | Biopsychosocial model

4 Competency: Describes the costs of obesity intervention and prevention with regards to the individual, the health care system, and community.

1	2	3	4	5	6	7	8	9
1	2			3			4	5
Knowledge regarding the direct, indirect and human costs of obesity is superficial.	Describes detail, the indirect, a human co of obesity Knowledg regarding costs of o interventio at the indihealth car community population is limited.	e direct, and osts ge the besity on and n efforts ividual, e system, ity, and on levels	contradirect and hof obecosts of interverse at the health common popul levels. informinform	pares ares ares the sits the uman of obes ention ention ention unity, ation unity, ation to clinication the cl	ct, costs th the ity and fforts lual, ystem, and	Effectively efficiently peers and munity moncerning costs of orin relation costs of orintervention applies known of the costs of the co	educates I com- nembers ng the besity n to the besity on and n efforts. nowledge its of nd revention vention decision- quality nent	Has an advanced and detailed understanding of the costs of obesity and obesity intervention and prevention efforts. Participates in cost-benefit analysis and contributes to peer-reviewed literature. Effectively and efficiently educates policy makers with regards to the costs of obesity in relation to the costs of obesity intervention and prevention.

