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 tal is reasonal sensitive a uses peoplanguage, organized complete few impodetails for with simple managem challenge	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 e, 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		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 app and fairly to patient modesty comfort ophysical examinat fairly com document of finding	rey es are ropriate sensitive s's and during ion; uplete tation	usually and for parsimple	nation y comp ocused, ique is y accura y ensur t's mod omfort g physic nation; mentati dings ar y comp rganize tients w e weigh gemen	ate, es esty cal on e llete d	Physical examinatis consists complete systematicand focus appropriation using accitechnique that ensurpatient's and complete well orgation for patient moderate manager challenge	ently ently e, ic, sed ately curate es modesty fort; atation gs is e and nized 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.

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 managementallengers.	enage- 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 pare center Couns usually for pare simple	seling is y efficie tients v e weigh gemen	ige- illy sing sed alth nge. ed are gh,	performe evidence- models o behavior	enanage- consistently ed using c-based f health change. evided are rough, ent- ing is etly for with e weight ment	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 personalizative manaplan for pwith simple 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		ystems stently in shared making to a 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		4	5	
Lacks basic	Has basic			/erage		Has above	е	Has exceptional
knowledge of	knowledg			edge o		average		knowledge of
overweight and	overweigl			eight a		knowledg		overweight and
obesity incidence	obesity in			y incide		overweigl		obesity incidence,
and prevalence,	and preva	•	•	ence, a		obesity in		prevalence, and
effects on	effects or			s, effect		prevalence		trends, effects on
morbidity and	morbidity		morbidity and			trends, ef		morbidity and
mortality, and	mortality,		mortality, and			morbidity and		mortality, and
demographic	demogra		demographic			mortality,		demographic
associations and	associatio			ations a	and	demographic associations and		associations and
distributions for	distribution			utions				distributions for
children and adults.	children a			ildren		distributions		children and
Cannot identify	adults. Ca	·	and a			for childre		adults. Demon-
common	identify co			nstrate	_	and adult		strates knowledge
environmental,	environm	,		edge o	t	Demonst		of common, subtle,
socioeconomic,	socioecor	-	comm			knowledg		and theorized
and behavioral	and beha			nment	•	common		environmental,
contributors to the	contribute			conom	-	tle enviror	•	socioeconomic,
obesity epidemic	obesity ep			ehavior		socioecor	•	and behavioral
at the population	at the pop	oulation		butors t		and beha		contributors to the
level.	level.			y epide		contribut		obesity epidemic
				popula	ition	obesity e		at the population
			level.			at the pop level.	pulation	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 homeosta weight reincluding and biochenergy stotransfer, the namics, and 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	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	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	ge of gies, ms, and	the eti mecha and bi obesit apply knowl	edge o iologies anisms iology o y, and o that edge to nical ca	s, , of can	Has above average knowledge the etiologomechanis and biologobesity, a can apply knowledge the clinic of patients	ge of ogies, sms, ogy of nd 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 knowledg obesity-re comorbid the corres benefits o reduction	elated lities and sponding of BMI	knowl obesit comor the co benefit reduct can ap knowl	verage edge or y-relate respondits of Bitton, and edge to nical calients.	ed s and nding MI d	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 knowledg the princi of primary secondary tertiary pri for the pri 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 esity, an oply tha edge to nical ca	nd ention ention ent d at	Has above average knowledge the principle of primar secondar tertiary properties for the principle of obesity can apply knowledge the clinical of patients.	ge of iples y, y, and revention evention ment y, and that ge to all 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 guidelii for the tre of obesity	je nes eatment	knowl guidel the tre of obe can ap knowl	verage edge o lines for eatmen esity, an oply tha edge to nical ca ients.	t d at	Has above average kind of guidelithe treatron of obesity can apply knowledge the clinical of patient Recogniz limitation guideline respect to individual patient can be seen to see the control of the co	nowledge nes for ment , and that ge to al care 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 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	ons eatment	for the of obe can ap knowl	edge rition entions treatn sity, an oply the edge to	nent d at	Has above average knowledge of nutrition intervent for the troof 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 knowledge physical a guidelines interventi the treatr obesity.	ge of activity s and ons for	knowl physic guidel interve the tre of obe can ap knowl	verage edge o al activ lines an entions eatmen esity, an oply tha edge to nical ca ients.	rity d for t d at	Has above average knowledge physical a guideline intervention the treatr of obesity can apply knowledge the clinical of patients.	ge of activity s and ions for ment /, 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	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 at 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		3			4	5
Does not	Recogniz	es an-	Has av	/erage		Has above	e average	Has exceptional
recognize anti-	ti-obesity	medi-	knowl	edge o	f the	knowledg	ge of the	knowledge of the
obesity medication	cation as	an ap-	age-a	opropri	ate	age-appr	opriate	age-appropriate
as an appropriate	propriate	opriate form of		pharmacothera-			othera-	pharmacothera-
form of therapy.	therapy, and has		peutic	option	s for	peutic op	tions for	peutic options for
Lacks basic	basic kno	wledge of				the treatr	nent of	the treatment of
knowledge of the	the age-a	ppropri-	obesity, including			obesity, ir	ncluding	obesity, including
age-appropriate	ate pharn	nacother-	their indications,			their indi	cations,	their indications,
pharmacothera-	apeutic o	ptions for	contra	indicat	ions,	contraind	ications,	contraindications,
peutic options for	the treatr	nent of	side et	ffects, a	and	side effec	ts, and	side effects, and
the treatment of	obesity, ir	cluding	mech	anisms		mechanis	sms of	mechanisms of
obesity, including	their indic	cations,	of acti	on, and	ł	action, ar	ıd can	action, and can
their indications,	contraind	ications,	can ap	ply tha	at	apply tha	t	apply that
contraindications,	side effec	ts, and	knowl	edge to)	knowledg	ge to	knowledge to
side effects, and	mechanis	sms	the cli	nical ca	are	the clinica	al care	the clinical care
mechanisms	of action.		of pati	ients.		of patient	S.	of complex
of action.								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-approbariatric sas an approform of the and the oavailable. basic know the mechal of action a metabolic outcomes	opriate urgery ropriate nerapy ptions Has wledge of anisms and c/clinical	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	ge ng s eatment	of obe	edge erging lities e treatn esity, an oply the edge to nical ca	d at	Has above average knowledge of emerge 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

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 strength and deficition in knowled obesity mand able to and achies limited going improvements.	gths iencies idge of iedicine, to set ive	some and de in kno obesity and ak achiev	o evalu strengt eficiend wledge y medic ole to se e some provem	chs cies e of cine, et and goals	Able to exmost stree and deficin knowled obesity mand able and achies most goal improvem	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.

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	2	3			4		5
Unable to analyze practice systems using quality improvement methods to monitor and optimize obesity care.	Able to an some practice systems upon the desire to monitor and optimal obesity can be sity can be sit	ctice using aprove- thods or nize	a wide basic p system quality ment to mo and op	o analy e range oractice ns using y impro method nitor otimize y care.	of e g ove- ds	Able to an more adverse practice susing qualimproven methods monitor and optimobesity can	ranced systems ality nent to	Consistently able to analyze complex practice systems using quality improve- ment methods to monitor and optimize obesity care.

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 ut resources locate evi but unab interpret evidence scientific regarding treatmen co-morbic	dence, le to or apply from studies obesity t and its	resour locate and be to inte not ab evider scient regard treatm	o utilized rces to eviden eginnin erpret, k ole to ap nce fror ific stud ding ob nent an orbiditie	oce out oply m dies esity d its	Able to un resources locate and interpret and begin apply evid from scie studies reobesity trand its co-morbing to un resources.	s to d evidence, ns to dence ntific egarding eatment	Consistently utilizes resources to locate, interpret, and apply evidence from scientific studies regarding obesity treatment and its co-morbidities.

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	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 us few limited of informate technology to obesity treatment with an incomprehe and there unable to delivery of including software application related definitions.	d forms ation gy related t, but complete ension, fore optimize f care EHRs,	technorelated obesit to opt deliver include EHRs, applice	forms rmatio ology d to y treatr imize ry of ca	ment re re and	Able to us most form information technology related to obesity to to optimize delivery of care inclusion EHRs, soft application related de	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.

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

1	2	3	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 incomp education patients, s residents, other hea profession on the dis of obesity	olete n to students, and Ith nals	cation patien reside other profes on the of obe	les basi	d se basic	Effectively educates students, and other profession on the dis of obesity common advanced clinical ca	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)

1 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	5	6	7	8	9
1	2	2		3		4	4	5
Verbal, nonverbal, and written communication is biased, judgmental, disrespectful, and/ or not empathetic when communicating with patients with obesity.	Occasiona utilizes ve nonverba written communi that is inapprope when eng with patie obesity, b corrects v pointed o	rbal, l, and cation riate gaging ents with ut when	verbal and w comm that is when	ritten nunicat approp engagi patients	ion oriate ng		opropriate onverbal, en ication lored ual ances gaging ents with acluding ang	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	ritten nunicat appropengagi ecare sionals 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 apprector for cultural diversity appreference community with other corrects we pointed of	iation al and es when cating rs, but vhen	appreculture and powhen cating and monofinter	enstrate ciation al diver referen comme with o nakes us erpreter es when ted.	of sity ces uni- thers se	Consistent demonstration an apprect of cultural and prefer when concating with consistent uses interservices windicated in challent situations addresses adversity or denial change. Recognizing implicit a explicit bit patients, it staff, and	rates ciation I diversity rences mmuni- th others, tly repreter when and aging s, s to es and ias in family,	Consistently demonstrates an appreciation of cultural diversity and preferences when communi- cating 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 extwhen counselin patients a families williving with overweigh obesity, b corrects with pointed of the counsel of the corrects with the correct of the co	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	ess, ias eling I	Consister exhibits competed honesty, responsible trustworth and lack of when coupatients a families williving with overweigh obesity, 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	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 respectfu behavior a exhibits b working v patients a families w are living overweigh obesity, b corrects v pointed o	onate, I and ias when with ind with ot or ut when	and rebehave of bias ing winot all families living v	ts assiona espectfor ior and s when th mos patien es who with ov t or obe	ul lack work- t if ts and are er-	Consister exhibits compassi and respective behavior of bias who working water than the control of the control o	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	:	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 do in detail, to of practic physician advanced providers allied heat professional members a superficunderstate of the role various comembers cies, and makers in prevention treatment obesity.	che scope e for s, l practice and lth hals, sistently nterpro- team s. Has ial 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 ty. Clear lates anisms ch isciplin 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 ce obesity n and ion ty settings. perficial nding 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	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- t bias; proactive reduce as within al setting	for pe demo respec care; p seeks weigh the cli howev reduct of wei the co	nstratirectful paroactive to reduct bias ver, effore the efformmun olicy le	ng itient /ely ice vithin etting; orts to ffects s at ity	weight bi educate p actively e	as within al setting it; y utilizes ssional and available regarding ias 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, a tion within communit public potings is lin	various isease t and n models; applica- n clinical, ty, and licy set-	based clinical decision in the individual overwork obesit engage with a obesit familial barries within ment care distinct care d	s popul data to al pract on-make care of duals we reight o by; actives es indiveryes and the est one and he eliveryes; how oordinated to head eliveryes; applicated in community	o drive ice king ith rely iduals ght or heir duce ealth over, ation alth cation nunity olicy	Effectively efficiently coordinate comprehe patient-coare in both and community settings; a within the policy dollimited.	ees ensive, entered th clinical munity pplication e public	Actively advocates for public policy changes that reduce environ- mental 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 interventation the health common popul levels. informinform	pares areasts the asts the uman of obes ention ention ention unity, ation unity, ation to clinication the clin	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 d com- nembers ng the besity n to the besity on and n efforts. nowledge ets of nd revention vention decision- quality nent and	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.

