

This brief will 1) evaluate the promise of, and need for, health equity; 2) explain what lifestyle medicine is and why it is high-value care; 3) share how provider organizations can deliver lifestyle medicine both through their own processes and through community partnerships; and 4) present some of the challenges to widespread adoption of lifestyle medicine and how those challenges can be addressed.

This paper is has been produced in partnership with, and through the generous sponsorship of, the American College of Lifestyle Medicine. The Institute wholeheartedly supports the principles of lifestyle medicine as a means to achieving health value.

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Reducing health disparities, the differences in health outcomes between populations, is a promising opportunity for reducing unnecessary human suffering and unnecessary health care spending. One of the most common manifestations of health disparities is in the higher prevalence of lifestyle-based chronic diseases in historically marginalized populations, stemming from disparities in the drivers of health, also known as social determinants of health. By addressing chronic diseases through lifestyle behavior, lifestyle medicine is a promising approach for addressing health disparities and achieving health equity. Lifestyle medicine is an evidence-based therapeutic approach that focuses on six pillars: a whole-food, plant-predominant eating pattern, physical activity, restorative sleep, stress management, avoidance of risky substances, and positive social interactions. Organizations engaged in value-based care should consider lifestyle medicine as an approach to improve health outcomes, reduce unnecessary spending, improve patient and physician satisfaction, and eliminate health disparities. While there is growing evidence of the effectiveness of lifestyle medicine for treating and reversing chronic disease, there is still much to be done to accelerate the adoption of lifestyle medicine more broadly.

Introduction

In recent years, the ways in which historic and existing policies have created and exacerbated inequities in historically marginalized populations have been elevated in the national consciousness. And these inequities – the gap in outcomes between one group and another – exist within a number of social dimensions including health and health care. Consequently, efforts to address these disparities and achieve health equity have also increased.

According to the Centers for Disease Control and Prevention (CDC), health equity is achieved when everyone “has a fair and just opportunity to be as healthy as possible and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to [treatment](#). This objective is daunting but crucial and will require work on many fronts involving patients, providers, payers, and policy makers. Chronic disease is an obvious priority area to target.

The evidence of health disparities is abundant and is readily found when examining the health status of any historically marginalized group or the effects of nearly every disease. This is a difficult reminder of the way that policies and structural factors have disadvantaged certain communities, and it also reveals areas where substantial improvement opportunities exist.

To give a few examples, Native American adults are [twice](#) as likely to be diagnosed with diabetes than non-Hispanic white adults and Black and Hispanic adults are also at increased risk ([60%](#) and [70%](#), respectively). [Hispanic adults](#) diagnosed with diabetes are [twice](#) as likely to develop end-stage renal disease as a result and Black people with diabetes are [four times more likely](#) to have a resulting amputation. Black and Hispanic Medicare beneficiaries have higher rates of hypertension ([79%](#) and [65%](#), respectively) than white beneficiaries ([60%](#)). And Black women are [twice](#) as likely to suffer from stroke as non-Hispanic white women of similar ages. Finally, obesity, a chronic disease on its own and a risk factor for numerous other chronic diseases, is [more prevalent](#) among Black, Hispanic, and Native American populations than among the general population.

The factors that have led to these disparities persist and, unless they are addressed at their root, will continue to cause unnecessary suffering. These disparities are the result of complicated interactions between multiple factors. Perhaps the most important upstream factor contributing to health inequity is structural racism. Experiencing the effects of racism is a stressor that erodes emotional, mental, and physical health. It also contributes to a lack of access to jobs, education, and homes, which exacerbates inequities in other drivers of health.

Understanding these “drivers of health” helps to explain these disparities in chronic disease incidence and outcomes. These [“conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes,”](#) heavily influence the health behavior choices that are available to people and the decisions that they ultimately make, which can contribute to the development and progression of chronic disease. To make progress on a large scale, improvements must be made to reduce food insecurity, food deserts, transportation challenges, poverty, and other drivers of health.

Population health research also shows us that the American health care system is not immune to institutional racism. In controlling all variables that may contribute to health disparities (e.g., food insecurity, education, income, access to health insurance), racial and ethnic minorities still have worse health outcomes. This demands that we reevaluate how health care is delivered in the United States. To address the alarming

trajectory of lifestyle-related, non-communicable chronic disease and its associated human and financial cost, we must consider the opportunity afforded by provision of a new specialty--equitable, evidence-based lifestyle medicine to prevent, treat and reverse the cause of most conditions that disproportionately affect our most medically under-resourced populations.

This paper will 1) evaluate the promise of, and need for, health equity; 2) explain what lifestyle medicine is and why it is high-value care; 3) share how provider organizations can deliver lifestyle medicine both through their own processes and through community partnerships; and 4) present some of the challenges to widespread adoption of lifestyle medicine and how those challenges can be addressed.

The Promise of Health Equity

While the overriding reason to work towards achieving health equity is to alleviate the toll of unnecessary human suffering and correct the injustice of past oppression, there are many secondary benefits of health equity, many of which are not limited to those currently experiencing the effects of disparities.

One of these secondary benefits is financial. A huge amount of excess health care spending can be linked to health disparities. [Research](#) conducted by Deloitte sought to estimate the economic costs of health disparities, by estimating the proportion of spending on several high-cost diseases that could be attributed to inequities. They estimate that disparities are currently responsible for \$320 billion in annual health care spending and their model shows that this could increase to \$1 trillion by 2040. A different [analysis](#) estimated the cost of lost productivity related to disparities to be \$42 billion, not counting loss from premature death.

In addition to alleviating the effects of poor health, promoting health equity also has the potential to ameliorate disparities in other social factors such as education and income. Poor health and disease can drain the time and energy required to attain a person’s full educational and professional potential. Even for those not directly affected, the demands of being a caregiver, or the psychological toll of having a loved one experience a disability or premature death may adversely impact [educational](#) and [professional](#) attainment.



Another benefit ties directly to the COVID-19 pandemic. For many, the pandemic illustrated how health is interrelated in a way that was not previously well understood. Clearly, an individual's susceptibility to contracting the disease was largely a product of the disease prevalence in their surrounding community. It was also affected by their ability to receive non-COVID related medical attention that was sometimes limited due to the pandemic.

Tragically, the pandemic [disproportionately](#) impacted communities that were already disadvantaged. There are two factors that are frequently put forward to explain this phenomenon. One is that existing health disparities and [higher frequencies](#) of comorbidities among these populations increased the odds of contracting the disease and developing severe symptoms. The second is that racial bias in the medical system may have sometimes contributed to inferior diagnosis in treatment and ultimately led to [worse outcomes](#). A striking example of this is the tragic and unnecessary death of Gary Fowler detailed in the Oprah Winfrey documentary, [The Color of Care](#) and a [Race to Value](#) podcast episode. Striving for health equity would seek to address both factors, reducing the impact of a pandemic on marginalized communities, in addition to reducing a disease's ability to spread to other communities. Reducing health disparities should therefore be viewed as a strategy for improving preparedness for a future pandemic.

Health Equity in Relation to Lifestyle Medicine

EFFORTS TOWARD ACHIEVING HEALTH EQUITY

Fortunately, as the consequences of health disparities are becoming better recognized and understood, numerous efforts are gaining momentum toward achieving health equity. The most prominent of these came directly from the White House in 2020. On the first day of his administration, President Biden issued executive orders which led to the creation of the [Presidential COVID-19 Health Equity Task Force](#) and the [Interagency Task Force on Equitable Data](#). Additionally, the Health and Human Services secretary, along with other agency heads, was directed to identify and address barriers to equity within the agency, which led to the creation of the [HHS Equity Action Plan](#). More recently, in late September of 2022, the administration will host the [White House](#)

[Conference on Hunger, Nutrition, and Health](#) to kick-off a nation-wide strategy to address food insecurity and diet-related diseases, which are some of the leading causes of death and disability in the U.S. and whose toll disproportionately impacts medically underserved communities.

State and local governments are also engaging in efforts to address health disparities in their constituent areas. In 2020, North Carolina created [The Andrea Harris Social, Economic, Environmental, and Health Equity Task Force](#) "to create economic stability, eliminate health disparities, and achieve environmental justice." Indiana, Nevada, and Louisiana recently began requiring Medicaid managed care organizations to submit [annual health equity plans](#) describing how they would address disparities in their served populations. In Chicago, the [Racial Equity Rapid Response](#) team was created as part of the city's COVID-19 response and as a broader initiative, Healthy Chicago Equity Zones were created to address the drivers of health disparities through hyper-local strategies. Myriad other initiatives are being deployed across the country to address health disparities and while there is much work yet to be done, there has never been so much energy directed at achieving health equity.

ACHIEVING HEALTH EQUITY THROUGH LIFESTYLE MEDICINE

Lifestyle medicine is one of the most promising approaches that health care providers can use to achieve health equity. The most common and most serious chronic diseases (cardiovascular disease, diabetes, stroke, dementia, and cancer) are [impacted by lifestyle choices](#). Given the prevalence and severity of these conditions, it is not surprising that some [estimates](#) indicate that 90% of all healthcare spending is for conditions rooted in unhealthy lifestyle choices.

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6 WAYS TO TAKE CONTROL OF YOUR HEALTH

[Lifestyle medicine](#) is the use of evidence-based lifestyle therapeutic approaches as a primary modality for the prevention, treatment, and, when used intensively, often reversal of lifestyle-related chronic disease. There are six pillars through which it typically works:

- ▶ a whole-food, plant-predominant eating pattern
- ▶ physical activity
- ▶ restorative sleep
- ▶ stress management
- ▶ avoidance of risky substances
- ▶ positive social connections

Rather than just managing the symptoms of individual chronic diseases or conditions, lifestyle medicine takes a whole-person approach that aims to restore health by treating their root cause(s). This is not to say that medications and procedures should not be employed when appropriate, but rather to emphasize the centrality of lifestyle as the first line of treatment, as recommended in most [chronic disease clinical practice guidelines](#). It is a unique method to delivering care that requires a change in focus and process, not something ancillary that can just be tacked on to a physician visit.

The health behaviors that are central to lifestyle medicine have been shown to have enormous potential for preventing many types of disease, but it would be a mistake to view it as just a preventive effort. It is a

therapeutic treatment approach that seeks to restore health as a clinical outcome by addressing the root causes of disease. Research such as that led by [Dr. Dean Ornish, considered a founding father of lifestyle medicine and recipient of the ACLM Lifetime Achievement Award](#), has shown that lifestyle changes can halt and reverse the progression of heart disease and other chronic diseases. The [Ornish Program for Reversing Heart Disease](#) is the first program to be covered by Medicare under the category of Intensive Cardiac Rehabilitation. Per CMS, "Such increased access to important lifestyle medicine programs like this will continue one of Medicare's very important missions to decrease disparities amongst beneficiaries." To learn more, listen to the [Race to Value Podcast featuring Dr. Ornish](#), entitled The Future of Value: Lifestyle Medicine and the Reversal of Chronic Disease.

"When we treat the cause, these lifestyle choices, our bodies have a remarkable capacity to begin healing and much more quickly than we once realized."

- Dr. Dean Ornish, Founder and President,
Preventive Medicine Research Institute

To be effective, lifestyle medicine must support behavior change and account for the unique circumstances of the patient's life. Understanding the drivers of health and how they affect a patient's health behaviors and condition is a critical part of lifestyle medicine. Empowering patients to make healthier choices through education is also critical, but education alone is insufficient. Where possible, the factors driving health must be addressed directly. This is not an easy task, but there are already a number of innovative approaches involving health care payers, providers, government agencies, and community organizations currently underway.

Lifestyle Medicine and Value-based Care

LIFESTYLE MEDICINE ACHIEVES THE QUINTUPLE AIM

Because it focuses on addressing the root causes of disease instead of medicating and managing symptoms, lifestyle medicine is inherently high-value care. In the long run, improving the health behaviors of patients is the most effective way to reduce the total cost of care,

especially for some of the costliest patients – those with chronic diseases. By emphasizing healthy behaviors over costly procedures and medications, providers engaged in value-based care can lower health care costs while still maintaining high-quality standards and improve outcomes.

“Lifestyle medicine needs to be looked at synergistically with Western Medicine. Everything in health begins and ends with lifestyle.”

- Dr. Sean Hashmi, Regional Director
Clinical Nutrition and Weight
Management, Kaiser Permanente

The whole-person approach of lifestyle medicine as well as the significant health improvements that it yields can also improve patient satisfaction—the person-centered focus of lifestyle medicine highlights and accelerates the achievement of outcomes that matter to the patient. As patients succeed in implementing new behaviors their confidence and ability grows, leading to more effort and better results.

Lifestyle medicine also advances provider satisfaction. For physicians and other providers who chose medicine as a profession out of a desire to help people achieve their full health potential, lifestyle medicine offers an alternative to the high-volume, disease management-focused status quo. Given the number of providers experiencing burnout, this positive impact on provider morale could be significant.

In January 2022, a [JAMA Network opinion](#) proposed adding to the “Quadruple Aim” of improved outcomes, lower costs, patient satisfaction and provider satisfaction, a fifth aim of advancing health equity. Lifestyle medicine, already addressing the first four, has the potential to meet this new aim by preventing and treating lifestyle-related chronic disease health disparities.

Under fee-for-service, only a limited set of activities can be considered financially justified, but value-based care creates space for providers to engage and invest in any activities that can improve health outcomes in a cost-effective way. This opens the door for providers in value-based care to be the vanguard of lifestyle medicine by engaging innovative approaches to promote healthy behaviors and address the drivers of health.

INTEGRATING LIFESTYLE MEDICINE WITH VALUE-BASED CARE

Training and Resources for providers

Even though physicians view it as their responsibility to educate patients on healthy behaviors, [most](#) do not receive adequate training on patient education and counseling to do so effectively. Fortunately, there are several resources available to train physicians and other providers on how to effectively deliver lifestyle medicine. The American College of Lifestyle Medicine (ACLM) offers multiple online CME and CE [courses](#) along with in-person and virtual conferences. The American Academy of Family Physicians offers a CME [course](#) and implementation guide to aid physicians in integrating lifestyle medicine into their practice. Additionally, other CME courses on lifestyle medicine can be found on the [AMA Ed Hub](#) and other learning platforms.

These resources give providers the skills and confidence that they need to provide effective lifestyle medicine to their patients. Those who complete a certain threshold of training are also eligible to become certified by the American Board of Lifestyle Medicine (for physicians) or the American College of Lifestyle Medicine (for other professionals). Organizations exploring the opportunity of lifestyle medicine can begin by encouraging providers, in whatever ways are appropriate, to take advantage of these trainings.

Innovating Care Delivery

In addition to appropriate training, it is important to equip providers and care teams with the resources and flexibility they need to engage in this new approach. Organizations must provide tools and processes to capture information about lifestyle factors such as dietary history and eating patterns as well as other drivers of health into each encounter. Allowing for longer visit times will be important so that providers can spend more time listening, educating, and counseling patients on their health behaviors. Patient trust is a critical component of lifestyle medicine and building trust invariably takes time, particularly among populations, including Black Americans who have an existing mistrust of medicine due to historical [mistreatment in research projects](#). Care teams may also need to take time away from seeing patients to redesign care processes with lifestyle medicine in mind. Incorporating new team members such as dietitians or health coaches can also be an important part of the lifestyle medicine team-based care approach.

One promising approach to lifestyle medicine involves the use of group medical visits, also called shared medical appointments (SMAs). These appointments bring multiple patients with similar health needs into a group setting. Instead of repeating patient education concepts with each patient individually, they can be explained once to the entire group. The group setting allows patients to share how they've understood the concepts and how they've applied them in their lives. The group also provides social support that can help motivate and sustain behavior change. With the appropriate accommodations, SMAs can be conducted either in-person or virtually. In either case, group visits should be paired with private time between the patient and provider to address individual questions and concerns.

"The combination of Lifestyle Medicine and Group Medicine are the potential foundation of the population care pyramid."

- James Maskell, Author,
The Community Cure

Some provider organizations are enabling lifestyle medicine through teaching kitchens. Teaching kitchens are an ideal setting for food literacy education. It allows patients to learn about healthy foods as more than abstract ideas: they apply lessons in preparing the food, and experience a connection to the food through sight, touch, smell, and taste. Many provider organizations have built teaching kitchens in their hospitals and clinic locations. Eskenazi Health in Indianapolis, IN, has gone a step further, by turning the roof of their outpatient care center into a [sky farm](#) where fresh vegetables are grown. The vegetables are used in the cafeteria, for patient meals, and sent home with patients participating in food literacy education.

Teaching kitchens are an ideal setting for food literacy education.

Produce prescriptions and food pharmacies are another approach to enabling patients to make healthier food choices. Produce prescription programs allow physicians to write prescriptions for healthy food to indicated patients. Receiving a prescription for healthy food emphasizes to the patient the importance of dietary

choices for their health in a way that education alone cannot. In some cases, food recommendations can be customized specifically for the individual's unique health needs. These are called [medically tailored meals](#). Depending on the food prescription program, patients may also be able to receive healthy food for free or at a substantial discount. Many produce prescription programs work in conjunction with food pharmacies, locations where the healthy food can be dispensed. Sometimes these are actual licensed pharmacies, but they can also be dedicated spaces within hospitals and clinics.

Food pharmacy programs have shown promising potential. Geisinger Health [System's Fresh Food Farmacy](#) Initiative for patients with type 2 diabetes and food insecurity provides patients and their families with five days' worth of healthy foods along with 15 hours of disease and nutrition counseling. After 18 months, HbA1c levels fell by an average of 2.1 points. There were also improvements in cholesterol, hypertension, and weight. For the patients that were insured by Geisinger, health care spending was reduced by 80%.

More than [65 health systems](#) have joined the ACLM's Health Systems Council in its first year and others are undoubtedly engaging in lifestyle medicine independently. Some brief highlights include:

- ▶ Massachusetts General Hospital Healthy Lifestyle Program, Boston, MA: The [MGH Healthy Lifestyle Program](#) was founded in 2019 and currently includes over 50 MGH primary care physicians and nurse practitioners, health and wellness coaches, and dietitians. The Healthy Lifestyle Program offers MGH primary care patients lifestyle medicine virtual group visits as well as health and wellness coaching.
- ▶ North Star Health, Springfield, VT: this FQHC program provides lifestyle medicine care, including the [Pivvio Program](#) and lifestyle medicine health and wellness coaching.
- ▶ Eskenazi Health Healthy Me program, Indianapolis, IN: [Healthy Me](#) is a free wellness program that focuses on lifestyle management by supporting patients and employees of all ages in their efforts to improve their overall health and well-being.

Lifestyle Medicine Through Community Partnerships

Lifestyle medicine is not constrained to health care settings and some of the most promising opportunities for lifestyle medicine involve working with aligned organizations within the community. Partnering with community organizations can lead to more culturally

appropriate services and help to establish trust with the intended population. This is particularly true with faith-based organizations. Another advantage of these partnerships is that existing familiar locations, like churches and community centers, can be used to bring lifestyle medicine to the population. Teaching kitchens, for example, have been implemented in both [YMCA](#)s and [churches](#).

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Community partnerships are also essential for changing the drivers of health that shape health outcomes. For example, St. Luke's Health System in Boise, ID, has partnered with a [community YMCA](#) to offer a lifestyle medicine clinic within the YMCA facility. The clinic offers classes and counseling related to nutrition, cooking, exercise, smoking cessation, and emotional wellness. Patients can also use the facility's equipment to exercise on site.

As another example, The [Massachusetts Food Trust Program](#) is a public/private partnership working to ensure access to healthy food for residents living in food deserts (areas where healthy food is not available). The program provides loans, grants, and business assistance to support the emergence of healthy food retailers in areas with limited options. Projects include small and mid-sized grocery stores that foreground fresh fruits and vegetables as well as farmer's markets and farm co-ops. The Go Fresh Mobile Market brings fresh fruits and vegetables to different food desert locations across Springfield, MA. In addition to food, some locations also offer food literacy education.

Changing the factors that shape health is an overwhelming challenge but working together through partnerships with similarly minded organizations can yield dramatic and long-lasting improvements. As an example, in his book, *The Community Cure*, James Maskell highlights examples of communities that purchase, grow and cook together and have been successful in

addressing food desserts and other social determinants of health. To learn more, listen to [Evolution of Medicine: Community-Based Health Transformation](#) and the [Reduction of Chronic Disease](#).

Payers and employers are other potential partners that can help to advance lifestyle medicine. Both have strong incentives for improving health and reducing health care spending and are starting to recognize the benefits of lifestyle medicine. MetroPlusHealth, which provides insurance to New York City employees as well as others, recently began offering a [no-cost dietitian benefit](#) to enable employees to meet individually with a dietitian and attend group education opportunities. Many employers are already acquainted with worksite wellness programs and other expanded health benefits, but too often the results of these programs are [underwhelming](#). Programs that incorporate the evidence-based practices of lifestyle medicine [may prove more effective](#) at achieving the intended results.

Challenges and Pathways to Lifestyle Medicine Adoption

CHALLENGES TO ADOPTING LIFESTYLE MEDICINE

While there is a growing body of evidence showing the promise of lifestyle medicine, there remain several challenges that must be overcome to ensure its widespread adoption and success.

First, within health care, provider education remains a substantial barrier with few physicians receiving adequate training on lifestyle medicine or assessing the drivers of health as part of their formal medical training. Since 1985, the National Academy of Sciences has recommended a minimum of 25 hours of nutrition counseling training, yet only [27%](#) of US medical schools do so currently. Consequently, only [14%](#) of medical students feel equipped to provide such counseling. A 2021 survey of undergraduate medical students showed that [95.2%](#) believed that were they trained sufficiently, they could more effectively serve as a healthy lifestyle role model for their patients. Only the University of South Carolina Greenville School of Medicine requires [lifestyle medicine education in all four years](#).

Second, certain racial and ethnic groups are underrepresented in the medical profession, which may



contribute to a lack of patient trust since [research](#) has shown greater levels of patient satisfaction when patients have racial concordance with their physician. A 2021 Gallup [poll](#) revealed that most Black adults have a hard time finding a doctor that shares their race. Furthermore, respondents within that majority were twice as likely to report that a doctor didn't listen carefully or didn't believe they were telling the truth. And although the numbers are slowly improving, Black students still only make up [11.3%](#) of those entering medical school while those of Hispanic, Latino, or Spanish origin only make up 12.7%—numbers that are not going to substantially impact the U.S. diversity deficit anytime soon. Health care organizations will have to hire proactively to overcome decades of policies that failed to produce a workforce that reflects the diversity of the communities being served.

Third, the misaligned financial incentives of the U.S. health care payment system continue to hinder innovation in care delivery. While value-based care is expanding the possibilities over fee-for-service, limitations on reimbursement for lifestyle medicine activities continue to be a barrier to widespread adoption. These reimbursement challenges include:

- ▶ Inadequate or no payment for the unique services of lifestyle medicine
- ▶ Reimbursement for all members of the care team providing lifestyle medicine services
- ▶ Quality measures that are based on process and medication adherence, rather than outcomes and health restoration
- ▶ Reimbursement for care delivered outside traditional medical office facilities.

The restrictions on reimbursement for care outside traditional medical facilities were initially developed to prevent abuse under the volume-based, fee-for-service payment models. These site-of-care requirements have the effect of preventing care delivery from taking place in settings—like a church, YMCA, or a teaching kitchen—that are much closer to the people in the community and in an environment that is much more conducive to a collaborative, healing relationship. Such restrictions also prevent more effective—and cost-effective—delivery approaches like group medical appointments, which are more feasible when conducted in community facilities.

Finally, there are also pervasive misconceptions about food and a lack of food literacy in general that inhibit the widespread adoption of healthy food choices. Many people wrongly believe that eating fresh fruits and vegetables is too expensive or that animal-based foods

are the only source of protein. Additionally, the ubiquity of inexpensive, unhealthy foods and advertising for them can overwhelm a person's decision-making even when they understand the importance of healthy food and have reasonable access. Government subsidies of the food industry are too often directed to these [less healthy](#) types of food. Together these conditions create an environment where it is significantly easier to make unhealthy dietary choices than healthy ones.

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ADVANCING LIFESTYLE MEDICINE ADOPTION

Overcoming the challenges to lifestyle medicine adoption will require a multifaceted approach. Fortunately, much of that work is already underway. As mentioned, the [University of South Carolina Greenville Medical School](#) was the first to integrate lifestyle medicine into all four years of its curriculum and other medical schools and schools of public health have begun to add lifestyle medicine courses to their curriculum.

The lifestyle medicine approach is resonating with medical and other health professions students at the grass-roots level. In 2009, there was one ACLM Lifestyle Medicine Interest Group (LMIG) on a medical school campus; in 2022 there are now 95 LMIGs (at 69 medical schools, 6 in bachelor's level programs, 13 in master's/doctoral programs, and 7 in health systems). In terms of residency, an ACLM residency program curriculum started in July 2018 with 4 pilot sites and 5 programs, with 80 faculty and residents enrolled. In 2022, there now are 175 residency programs implementing across 89 sites, with 1,099 faculty and 3,654 residents.

For medical professionals who have already completed their training, the American College of Lifestyle Medicine offers CE/CME credits as well as preparation for the American Board of Lifestyle Medicine certification for physicians and ACLM certification in lifestyle medicine for other clinicians. Today, 2,004 physicians in the U.S.

have become board certified in lifestyle medicine, along with 778 other health professionals. Globally, 3,225 physicians are now certified as well as 1,018 other health professionals.

ACLM's HEAL (Advancing Health Equity Through Lifestyle Medicine) Initiative scholarship provides financial support to eligible underrepresented in medicine (UIM) professionals pursuing lifestyle medicine certification, addressing the need for more diversity in the lifestyle medicine workforce.

As discussed earlier, community partnership initiatives can be an effective approach to addressing the drivers of health that contribute to health disparities. Across the country, numerous pilots and initiatives are already underway. These initiatives should be encouraged, supported, and evaluated so that successful approaches can be deployed at a larger scale.

It is essential to use public policy levers at the national, state, and local level to continue to accelerate the adoption of lifestyle medicine. Advocacy should focus on policies that shift government subsidies to healthier foods, change dietary recommendations to better emphasize plant-based foods, provide more and more flexible reimbursement options for lifestyle medicine activities, and further encourage the integration of lifestyle medicine into medical education.

Widespread adoption of lifestyle medicine would represent a dramatic shift in how chronic diseases are treated. Rather than focusing on managing the symptoms of the disease, providers and patients would work together to restore health by changing the behaviors that contributed to the disease. This change in paradigm may be exactly what is needed to alleviate the pain and suffering of individuals and achieve health equity.

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About the Institute

The Institute for Advancing Health Value (the Institute) is a non-profit organization with a mission to accelerate the readiness of health care organizations to succeed in value-based payment models. Founded by former Secretary of Health and Human Services, Gov. Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, the Institute serves as the foundation for health care stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the Institute, visit advancinghealthvalue.org. The Institute is formerly known as the Accountable Care Learning Collaborative (ACLC).



About the American College of Lifestyle Medicine

The American College of Lifestyle Medicine (ACLM) is the medical professional society providing quality education and certification to those dedicated to clinical and worksite practice of lifestyle medicine as the foundation of a transformed and sustainable health care system. To learn more about the ACLM, visit lifestylemedicine.org.



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