AMERICAN COLLEGE OF Lifestyle Medicine

Lifestyle Medicine Interventions in Underserved Communities Continue to Improve Health Outcomes

Innovative approaches and strategic collaborations with community resources increase access to lifestyle medicine solutions for patient populations at a higher risk for lifestyle-related chronic disease.

Lifestyle risk factors, including poor nutrition, alcohol and tobacco use, and inadequate physical activity, which lead to chronic health conditions such as heart disease, obesity, cancer, and type 2 diabetes disproportionately affect communities of color and individuals living in rural and low-income neighborhoods.

While communities of color and other historically medically underserved populations face barriers created by social drivers of health (SDoH) that hinder access to care and behavior change support, leaders in the field of lifestyle medicine are actively and successfully working to address lifestyle-related chronic disease health disparities.

15%

ACCORDING TO THE CDC:

About 46 million Americans—15% of the U.S. population—live in rural areas. People who live in rural areas are more likely than urban residents to die prematurely from four of the leading causes of death: heart disease, cancer, chronic lung disease, and stroke.

Board-certified lifestyle medicine clinicians work in historically underserved regions across the country. In addition, they deliver care in various settings such as federally qualified health centers, rural health centers, safety net hospitals, and veterans health care settings as well as in health systems. Across settings and practice types, American College of Lifestyle Medicine (ACLM) members are prioritizing advancement of lifestyle medicine interventions tailored for patient populations disproportionately experiencing lifestyle-related chronic disease burden.

Solid examples of lifestyle medicine interventions benefitting some of our nation's most underserved populations continue to emerge and be documented. We see success in addressing health disparities through lifestyle medicine solutions when those who are championing lifestyle medicine lead collaborative efforts with community organizations.

This approach and model – working alongside community resources that are designed to empower residents – helps to improve behavior change success and mitigate the burden of SDoH that impede on one's ability to live a healthy lifestyle.

2X

ACCORDING TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF MINORITY HEALTH

In 2019 non-Hispanic Blacks were **twice** as likely as non-Hispanic whites to die from diabetes.

According to research, community-engaged lifestyle medicine (CELM) is an evidence-based, participatory framework capable of addressing health disparities through lifestyle medicine. Lifestyle medicine application in diverse, low-income populations is attainable via collaborative, multistakeholder, and community-engaged multi-pronged approaches. Many care settings deliver lifestyle medicine through community engagement, cultural competency, and application of multilevel and intersectoral approaches – the four key principles in the CELM framework.

Lifestyle medicine-certified clinicians have foundational training in behavior change theories and identify strategies that meet all patients where they are. The tables below showcase examples of how lifestyle medicine is being delivered through community engagement, cultural competency, and application of multilevel and intersectoral approaches. When CELM is the focus of lifestyle medicine intervention, lifestyle medicine trained medical professionals begin to break down access issues and other barriers to lifestyle medicine treatment, particularly in underresourced neighborhoods, thus improving health outcomes for all patients, no matter their zip code.

Community Engagement:

Community Engagement Core Principle	Partnership and engagement of at-risk community members and relevant stakeholders in health intervention
Program	Medically Tailored Meal Referrals @ UC San Diego Health + Mama's Kitchen
Example of LM Application	Patients at risk of malnutrition due to critical illnesses such as cancer, congestive heart failure, type 2 diabetes, and chronic kidney disease receive medically tailored meals and are offered the opportunity to meet with a registered dietitian to learn how to cook healthy meals.
SDoH Barrier Addressed	Nutrition Insecurity
Underserved Community Served	Medicare and Medicaid recipients
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Cultural Competency/Responsiveness:

Cultural Competency Core Principle	Receptiveness and awareness of patient's beliefs, practices, and social context; tailoring of care and recommendations to patient context
Program	Lifestyle Medicine Shared Medical Appointments @ Esperanza Health Center
Example of LM Application	In partnership with Get Fresh Daily, a community-based organization that provides healthy resources and culturally relevant programming, Esperanza Health Center patients with or at high-risk for chronic disease receive free weekly produce boxes that include vegetables, fruits, herbs, alliums, and immunity boosters. Patients then participate in culturally relevant group visits led in Spanish and focus on Hispanic cuisine.
SDoH Barrier Addressed	Nutrition Insecurity, Language Barriers and Food Desert
Underserved Community Served	90% of patients self-identify as Hispanic, Latino/a, or Spanish Origin
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Multi-level Approach:

Multi-level Approach Core Principle	Build/sustain healthy behaviors by addressing multiple levels of influence: individual, family, social linkages, neighborhood, culture
Program	The Healthy Neighborhood Immersion Strategy @ The Kellyn Foundation
Example of LM Application	The Lehigh Valley of Pennsylvania has over eight areas, home to more than 680,000 residents that meet the criteria of a "food desert." The Kellyn Eat Real Food Mobile Market is designed to help residents access fresh food choices through weekly visits to convenient neighborhood sites. In addition to mitigating the effects of food deserts, the Kellyn Foundation provides opportunities for participants to learn how to prepare healthier meal options through whole food, plant-based cooking classes.
SDoH Barrier Addressed	Food Desert Nutrition Insecurity
Underserved Community Served	Low-income
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Intersectoral Approach:

Intersectoral Approach Core Principle	Coordinate clinical services with resources and involvement of non–health care sectors (public, private, economic, social)
Program	Health and Faith Initiative
Example of LM Application	The Black church plays a major role in supporting the Black community to make sustainable lifestyle changes. Friendly Temple, a 5,000-member church congregation in St. Louis, MO, provided the congregation with resources that focused on healthy lifestyle changes, education on the role fiber foods play on health and diet, scripture-based content that aligns with faith and healthy living, and personal accounts and testimonies from race-concordant physicians. In addition, the church conducted an 8-week class (in-person and virtually) with 100 members who went through the Full Plate Living curriculum.
SDoH Barrier Addressed	Nutrition Insecurity Food Desert Transportation Access
Underserved Community Served	Black and African American
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Despite the challenges and limitations that exist, ACLM and our dedicated members strive to support patients no matter what their barriers may be. We highlight four of the many solid examples and implementation models that showcase success in the area of lifestyle medicine intervention in high-need patient populations. While we are not experts on mitigating the impacts of SDoH, we support our members in finding solutions to these challenges through our HEAL Initiative and its companion scholarship program, and other strategic partnerships with organizations aligned with our health equity efforts.

To learn more about community engaged lifestyle medicine examples improving health outcomes of historically medically underserved patients, visit lifestylemedicine.org/heal-initiative.