Policy Statement on Lifestyle Medicine

Policy Recommendation:
The American College of Preventive Medicine (ACPM) recognizes the importance of lifestyle interventions such as diet, physical activity, stress management, and emotional wellness in the prevention of chronic disease at all ages. ACPM supports evidence-based, lifestyle medicine principles and strategies in all physician practices[1,2]. Therefore, ACPM recommends and supports the following:

- Policy changes by medical certification bodies requiring education that contains principles of lifestyle medicine and the 15 core competencies as developed by the American College of Lifestyle Medicine and American College of Preventive Medicine[1].
- Legislation and regulatory policies incentivizing active patient participation in lifestyle changes and physician reimbursement for such initiatives, with encouragement of supporting actions by third-party payors for reimbursement mechanisms.
- Legislation that encourages adoption of lifestyle medicine principles, such as tax or policy incentives that promote healthy activities and grants for lifestyle-medicine related education or training guidelines.

Key Issues:

1. There is little to no education of medical students, residents, and practicing physicians on nutrition, nutrition counseling, physical activity counseling, and stress management.
2. Patients are not incentivized financially for lifelong lifestyle changes to improve and then maintain optimal health.
3. Physicians are not reimbursed for ongoing counseling of patients, including out of office, on nutrition, physical activity, stress management, and other lifestyle factors that have been shown to improve and then maintain optimal health.

Supporting Evidence:

1. **There is need for significant improvement in nutrition education for medical students in at least 8 core areas. This education is supported by learners and educators yet is rarely available in any significant, meaningful curriculum. This should be part of minimum standards for medical education. Similarly, there is need for improvement in medical education on evaluating and coaching patients regarding physical activity and stress management techniques.**

The National Academies of Sciences, Engineering, and Medicine published a report in 1985 recommending at least 25 hours of nutrition instruction in 8 core competency areas[3]. Later, an

AJCN report recommended 37-44 hours of nutrition instruction during the 4-year, undergraduate medical education curriculum[4]. Subsequently, a study showed that while some programs had created nutrition programs, nationwide the state of nutrition education was uncoordinated and in need of specific nutrition competencies[5]. Furthermore, a need for ongoing education or initial education of resident trainees and practicing physicians was also demonstrated and tested[6,7]. The need for nutrition education in prevention and reversal of chronic disease has been previously reported[1,3]. There is also a need for physical activity education[8] and stress management education[9,10] as part of general medical education for effective and evidence-based delivery of primary and secondary preventive care in the clinical setting. Furthermore, current American Medical Association policy supports lifestyle medicine and education of its tenets at all levels of medical training and practice (H-425.972 adopted 2012 and revised 2017, Resolution 959 as amended at Interim 2017).

2. **Patients are not incentivized financially for lifelong lifestyle changes to improve and then maintain optimal health.**

Actuarial analysis has demonstrated that lifestyle change has significant impact on healthcare resource utilization, financial cost to the system, and individual health outcomes[11]. In fact, the current system in unsustainable financially due to misplaced priorities[12]. Case studies have even shown cost savings to physicians and organizations[13]. Yet, there are few financial incentives in the form of insurance savings or tax credits/deductions to patients, especially those in a disadvantaged category, to realize those changes. Tax deductions for gym memberships are limited in applicability and amount. Recent survey research showed that reimbursed gym membership had modest effects on compliance during the first 6 weeks[14] but there was no combined diet education program, coaching/counseling, or follow up medical visits. However, full lifestyle medicine intervention with gym membership, coaching, and diet education did result in improvements in markers used for multiple, common, chronic illnesses[15]. Thus, with financial incentives for financially-at-need patients, motivation and compliance with treatment/counseling recommendations would be improved provided a comprehensive lifestyle medicine program was established for such patients.

3. **For broad use of lifestyle medicine principles and practices in primary care and clinical practice, physicians and other providers need adequate reimbursement for lifestyle medicine.**

A significant number of primary care physicians are willing and able to provide lifestyle-medicine education such as diet, physical activity, and stress management, provided they have the education and appropriate reimbursement[16]. Considering that the highest category of U.S. healthcare expenditures is in chronic disease management[17] and that two of the four goals of Healthy People 2020 deal specifically with disease prevention and healthy lifestyles[18], all physicians, but especially primary care specialty physicians, should be incentivized and reimbursed for promoting the evidence-based principles of a healthy (or healthful) lifestyle, collectively known as lifestyle medicine, by first promoting whole-food, plant-based nutrition,

through evidence-based programs for outcomes-based reimbursement. Furthermore, coaching/counseling as part of this comprehensive lifestyle medicine approach has been shown in the literature to be effective and durable[19,20]. Currently, there are very few private health insurance payors that reimburse for a full lifestyle medicine practice according to the guidelines set forth[1,2]. Private programs may be applied to third-party payors, but reimbursement is not guaranteed. It is also limited in which diagnoses it is applicable and is for 30 days only, not long-term. Currently, codes such as chronic care management (including group visits), intensive behavioral therapy for obesity, and the annual wellness visit are used by physicians for such practices. Thus, the availability and intensity of lifestyle medicine practices is limited. This prevents patients from seeking evidence-based, ongoing, durable advice on chronic disease prevention, management, and reversal. Promotion and reimbursement of such programs must be based on the preponderance of scientific evidence only, not commercial interests.

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