Application for a Focused Practice Designation (Read-only)

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Name of Sponsoring Board: American Board of Preventive Medicine

1. Provide the name of the proposed Focused Practice Designation (FPD):

   Lifestyle Medicine

2. If multiple Boards are interested in this proposed FPD and wish to collaboratively submit an application, please view the addendum found at the end of this application. Each collaborating Board should complete an addendum to describe specialty-specific modifications.

   It is the intention of ABPM to allow the FPD in Lifestyle Medicine to be open to all qualifying Diplomates from each of the 23 other ABMS Member Boards. Specifically, it is ABPM's intention to collaborate directly with the American Board of Family Medicine, American Board of Internal Medicine, American Board of Pediatrics and the American Board of Emergency Medicine. Despite that intention and due to time constraints and deadline requirements, ABPM cannot confirm formal participation from any of the ABMS Member Boards referenced above. Nevertheless, post submission of the instant Application, ABPM will engage directly with ABFM, ABIM, ABPeds and ABEM and amend this submission once formal participation is confirmed.

   a. Will there be Qualifying Boards for this FPD? If yes, please note which Member Boards will be Qualifying Boards.

      ABPM intends for each of the 23 other ABMS Member Boards to become Qualifying Boards with ABFM, ABIM, ABPeds and ABEM playing significant roles within the FPD structure.

3. State the purpose of the proposed FPD and include the rationale for how this FPD is different than other credentials approved by the ABMS, in two paragraphs or less:

   The purpose of the proposed FPD in Lifestyle Medicine (LM) is to formally recognize physicians who have acquired specialized, evidence-based competencies in the use of therapeutic lifestyle interventions to prevent, treat, and often reverse chronic diseases. These practitioners apply rigorous clinical expertise in whole-food, plant-predominant nutrition, physical activity, restorative sleep, stress management, connectedness, and avoidance of risky substances, combined with behavioral change strategies such as health coaching and motivational interviewing. As the burden of lifestyle-related chronic illness continues to rise, now accounting for over 80% of healthcare spending, there is a need for physicians trained in root-cause reversal and sustainable health behavior change. This proposed FPD in LM is distinct from existing ABMS certifications and subspecialties because it focuses not on organ systems or procedures, but on the modifiable behavioral determinants of health. Unlike traditional prevention or public health approaches, LM integrates lifestyle prescriptions directly into individualized patient care plans, often in coordination with pharmacologic or procedural therapies. While other specialties may address isolated lifestyle factors (e.g., cardiology addressing diet or psychiatry medicine addressing sleep), only LM is broadly-based allowing its practitioners to address all pillars in a structured, interdisciplinary manner. The LM FPD would provide a cross-specialty pathway for physicians to demonstrate validated expertise in this transformative approach to chronic disease care, currently unrecognized by ABMS certification.

4. FPDs typically fall under one of these areas. Please describe which of the following this application addresses:
    a. **Evolving area of practice**
    LM is an evolving area of practice that includes formal certification, medical society establishment, incorporation into medical education, and published literature. LM content is increasingly incorporated into undergraduate medical education, residency programs, and continuing medical education (CME), reinforcing its status as an evolving area of practice. In 2010, competencies for LM were created and published in JAMA. (Lianov L, Johnson M. Physician competencies for prescribing lifestyle medicine. *JAMA*. 2010;304(2):202-203. doi:10.1001/jama.2010.903).

    b. Area of practice limited in scope or size

    N/A

    c. Specialized procedure

    N/A

5. Please outline the eligibility criteria required of candidates in the proposed FPD, as it pertains to the following:

    a. What specialty and/or subspecialty certificate(s) will a diplomate be required to hold in order to be eligible for this proposed FPD?

    Diplomates in possession of certification from any of the 23 other ABMS Member Boards and otherwise meeting all then-current requirements will be eligible to sit for the assessment examination for an FPD in LM.

    b. Clinical practice experience (both in terms of time and patient volume) in the proposed FPD, beyond initial training:

    For those Applicants completing the Practice Pathway:

Clinical Practice Experience		
Topic	**Requirements**	**Comments**
Lifestyle Medicine approach in inpatient or outpatient clinical care settings	400 pt encounters	Address the six pillars of lifestyle medicine in clinical care: a whole food, plant-predominant eating pattern, physical activity, restorative sleep, stress management, avoidance of risky substances and positive social connections
Nutritional assessments and interventions	40 pt encounters	Food recall, nutrient analysis, percent body fat, and nutrition prescriptions
Physical activity assessments and interventions	40 pt encounters	Activity diaries, exercise capacity assessments, and exercise prescriptions
Emotional and mental well-being, sleep, and connectedness assessments and interventions	40 pt encounters	Stress and sleep assessments, depression/anxiety/mental health screening, monitor/improve heart rate variability, mindfulness, meditation, spirituality and emotional well-being activity prescriptions, and referral to resources
Tobacco and toxic substance assessment, brief intervention, and referral training	30 pt encounters	Smoking assessments, chemical and toxic exposure assessments, abstinence prescriptions, screening and brief intervention, and indications for referral
Interpersonal and community communication skills, practice-based learning and improvement, systems-based	not designated	Public relations campaigns, media campaigns, policy development and change, health system change, communication of risks vs. benefits, family and community engagement

practice, and leadership in policy and community		
(Intensive) Therapeutic Lifestyle Change (ITLC or TLC) programs	10 hours	Participation and/or observation in TLC /TLC group programs such as Pivio, LIFT, Full Plate Living, Diabetes Undone, DPP Optional: ITLC programs include Intensive Cardiac Rehab program (Ornish), McDougall program, Pritikin program
Support or coaching group facilitation	10 hours	Group observation, recording and facilitating – this may occur at the same time or separately from a ITLC/TLC program, must have 2 or more patients participate to count as group hours
Four case studies evidencing chronic disease reversal/remission in the four categories listed in the comments column. Generally, this will require at least two contact points over at least three months (Note: Only one case can be applied to a single patient).	Not time-based but case log requirement	• For all these conditions, cases reported should be changes obtained by lifestyle modifications and not by medication dosage adjustment. Patients can still be on medications, but the reported changes should occur through lifestyle modification. For instance, you could report a 10% drop in total cholesterol in a patient on a stable dose of statins who makes lifestyle changes, but NOT a 10% drop in total cholesterol in a patient who you simultaneously increase their statin dose and made lifestyle changes. • Remission is defined as the state of non-disease as determined by the failure to meet the recognized criteria for diagnosing the disease. This includes not only reducing the disease measures below the threshold for diagnosing the target disease/ condition but that this happens with an absence of medications or procedures known to affect those measures. • Include at least one case from each of the following areas: weight loss, insulin resistance reversal/remission, hyperlipidemia reversal/remission, hypertension reversal/remission

c. Additional qualifications (if any):

N/A

6. With regard to Board-based assessment for candidates prior to awarding this proposed FPD, which assessment methods will be required? (Check all that apply)

- **X Examination**
  - **X Written**
  - ☐ Oral/practical
  - ☐ Other (Please specify)
- ☐ Participation in a registry
- **X Submission and review of case lists**
- ☐ Review of patient charts
- ☐ Other (please specify)

a. Please describe the rationale behind the method(s) required in the assessment process:

The assessment process is designed to ensure that qualified practitioners possess a solid foundation in the science, clinical application, and behavior change principles central to LM. The rationale behind the methods used in the assessment reflects the interdisciplinary and evidence-based nature of LM, which focuses on addressing the root causes of chronic disease through lifestyle intervention.

A standardized, secure exam will evaluate the candidate's knowledge of core LM competencies, including nutrition, physical activity, sleep, stress management, substance use, and connectedness. It will also test understanding of behavior change strategies and evidence-based clinical practice. This method ensures objectivity and comparability across candidates. It aligns with other FPD processes (e.g., internal medicine, surgery, emergency medicine; obstetrics and gynecology).

In addition to the standardized exam and by way of further identifying Applicants who intentionally utilize LM principles throughout their practice, assessment will include a review of case lists. This supports the focused and practical application of LM principles in patient care. Applicants will be assessed on real-world competence, not just theoretical knowledge.

The assessment process combines knowledge testing, practical application, and standardized education to comprehensively evaluate an Applicant's readiness to practice LM safely and effectively. This multifaceted approach mirrors the holistic nature of LM itself, which spans science, clinical skill, and patient empowerment.

7. Please outline the Continuing Certification program planned for this proposed FPD, including whether the program is integrated with the continuing certification requirements for the specialty/subspecialty certificate it is tied to:

   The Continuing Certification Program (CCP) will include all requirements of ABPM's current CCP which include the following:

   - Maintenance of a full, valid and unrestricted license to practice medicine in every US state, US territory, or Canadian province in which the physician holds a license to practice medicine;
   - Pay the then-current Annual Fee for access to ABPM's Physician Portal, including but not limited to ABPM's Longitudinal Assessment Platform (LAP);
   - Annually complete a total 20 AMA PRA Category 1 Credits, each of which must be relevant to the physician's FPD in LM;
   - Annually complete ABPM's LAP in LM (achieving a Minimum Passing Score or MPS in four of the five administrations during the 5-year FPD cycle); and
   - Complete at least one Improving Health & Health Care (IHHC) activity during each 5-year FPD cycle.

8. Document the professional and scientific status of this proposed FPD by addressing (a) through (d) below.
   a. Please describe how the existence of a body of scientific medical knowledge underlying the proposed FPD is, in large part, distinct from, or more detailed than that of other areas in which certification or focused practice are offered:

LM represents a growing, evidence-based field that focuses on the prevention, treatment, and reversal of chronic disease through the use of validated lifestyle interventions. The scientific body of knowledge underpinning LM is both distinct and more detailed in several domains when compared to existing specialty certifications or FPDs. LM centers on six core domains: whole-food, plant-predominant nutrition; physical activity; restorative sleep; stress management; connectedness; and avoidance of risky substances. These are systematically addressed with clinical and behavioral approaches not covered in depth by most existing specialties.

Unlike traditional family medicine, internal medicine, pediatric or cardiology practice areas which may address some lifestyle factors in a broad manner, LM relies on a dedicated body of interventional science with clinical applications grounded in randomized controlled trials, cohort studies, and meta-analyses specific to lifestyle behavior change as the therapeutic agent.

For example, large-scale clinical trials such as the Diabetes Prevention Program (DPP) and the Lifestyle Heart Trial have shown that lifestyle changes can reverse or significantly reduce the risk of chronic diseases such as type 2 diabetes and cardiovascular disease (Knowler et al., 2002; Ornish et al., 1990). A meta-analysis by Esposito et al. (2014) confirmed that lifestyle interventions can reduce HbA1c in diabetic patients by levels comparable to first-line pharmacotherapy.

This field also incorporates advanced skills in behavior change theories (e.g., Motivational Interviewing, Health Belief Model, and Transtheoretical Model), culinary medicine, group visits, and health coaching techniques that are not systematically taught or required for certification in other specialties. LM's scientific depth includes a growing number of peer-reviewed journals and guidelines, such as:

- *American Journal of Lifestyle Medicine*
- *American College of Lifestyle Medicine Clinical Practice Guideline - Type 2 Diabetes (2025)*
- *Lifestyle Medicine (BMC)*
- *British Society of Lifestyle Medicine Clinical Guidelines (2023)*

A systematic review by Frates et al. (2021) noted that LM interventions delivered by trained clinicians lead to statistically significant reductions in BMI, blood pressure, lipids, and depression scores compared to standard care. These outcomes demand specialized training and a nuanced understanding of LM principles which are distinct from general primary care.

The proposed FPD in LM is supported by a robust and continually expanding evidence base that is distinct in focus, methodology, and clinical application and thereby warranting a dedicated designation to recognize physicians with advanced competency in this field.

a. Explain how this proposed FPD addresses a distinct and well-defined patient population and care need:

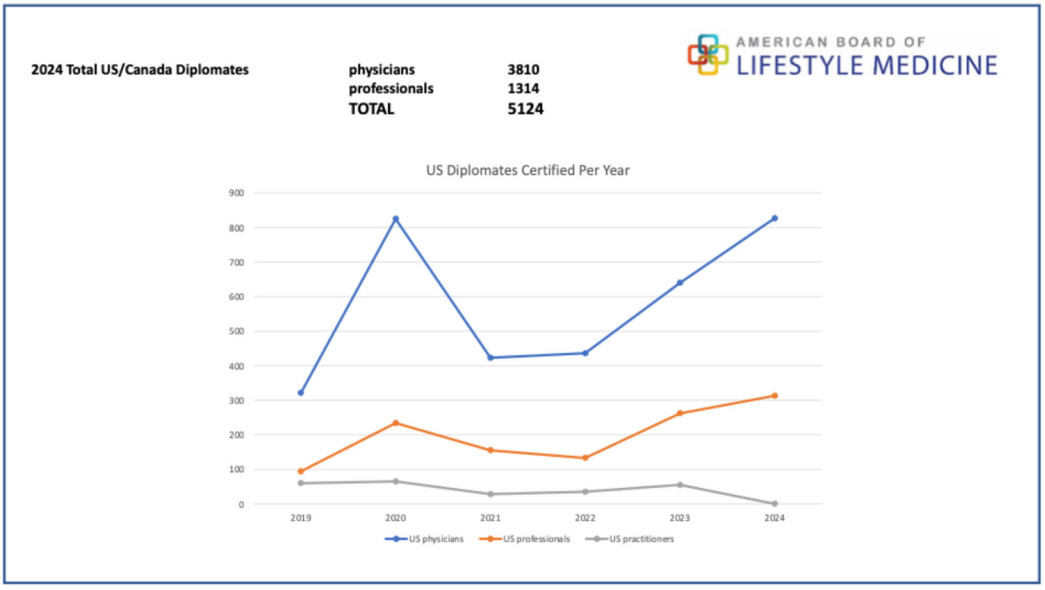
The proposed FPD in LM addresses a distinct and growing patient population: both adults and children with chronic, lifestyle-related conditions such as type 2 diabetes, cardiovascular disease, hypertension, obesity, metabolic syndrome, nonalcoholic fatty liver disease, and certain cancers. This population, now comprising the majority of adult patients in the U.S. requires a fundamentally different approach to care: one that goes beyond symptom management and targets the root behavioral and environmental causes of disease. These patients benefit most from interventions that improve nutrition, increase physical activity, reduce stress, restore sleep, strengthen social connection, and support lasting behavior change, all core competencies of lifestyle medicine physicians.

Current models of care often fail to provide sustained, personalized, and comprehensive lifestyle intervention. Despite decades of evidence supporting the efficacy of therapeutic lifestyle change in both preventing and reversing chronic disease (Ornish et al., 1998; Lean et al., 2018), most physicians report insufficient training in this area, and these services are inconsistently delivered. The LM FPD fills this care gap by credentialing physicians who are specifically trained to serve this underserved yet high-utilization patient population, using structured, evidence-based, and patient-centered approaches that complement and often outperform traditional pharmacologic therapies for long-term outcomes.

b. Please provide information about the group of diplomates concentrating their practice in the proposed FPD, if known:
    i. The projected number of such diplomates in total and annually (along with the source(s) of the data):

    ABPM has received information from ABLM which confirms that currently there are approximately 3800 ABLM certified physicians who, by default, have demonstrated their interest and specialization in the field of LM (See graphic below from the ABLM).

    Graphic included on next page.



This data suggests that between 2000 and 6000 US-based physicians are actively engaged with or concentrating part of their medical practice in LM. (Lianov L, Rosenfeld R, The Case for Physician Training in Lifestyle Medicine. https://pmc.ncbi.nlm.nih.gov/articles/PMC9989487/?utm).

Lower bound (~2,000): The number of ABLM diplomates who have completed ABLM certification requirements total roughly 2,000 US-based physicians. This number represents US physicians who are certified specifically in LM which provides a conservative floor for physicians concentrating their practice in LM.

Upper bound (~6,600): The ACLM reports approximately 11,000 members, 60% of which are MDs/DOs which is roughly 6,600 physicians. This group of physicians are ACLM members who can be considered to concentrate at least a portion of their medical practice in LM but who are not necessarily ABLM certified.

Therefore, a reasoned midpoint estimate of those US-based physicians who would be interested in achieving a FPD in LM from ABPM is roughly 4000. It is important to note that this estimate does not, of course, include the multitude of ABMS Member Board Certified Diplomates who concentrate a portion of their practice in LM and who would also be interested in an FPD in LM from ABPM.

ii. The annual rate of change of such diplomates in the recent past and projected annual rate of change for the near future (along with the source(s) of the data):

Projected annual rate of change is rather difficult but, based on the information in 8(b)(i) above, the Compound Annual Growth Rate (CAGR for ABLM-certified physicians from 2017-2022 was 65%. Further, the 5-year growth rate for those LM physicians who are also members of ACLM was 2.75x, resulting in a CAGR of 22-25% per year.

Of course, as with any such analysis, growth rates slow over time as the field matures and therefore, we can reasonably estimate near-term future annual growth in a range from a low of 10% to a high of 20%. In fact, ABLM currently approximates a 5-year annual growth rate of 10% which is consistent with ABPM's analysis and conclusions.

iii. The current geographic distribution of this group of diplomates, its projected spread in the next five (5) years, and an explanation of how you arrived at this projection:

Below is a "Heat Map" provided by ABLM which depicts the concentration of ABLM-certified physicians in the US. ABPM estimates that geographic distribution and concentration will be similar to that depicted on the ABLM graphic below.

c. Please identify the existing national societies that have a significant interest in the proposed FPD (include size, scope, and source of the data):

Below are the highest profile national-level medical societies and professional organizations that actively support or show significant interest in an FPD in LM. These groups contribute to advancing standards, competencies, and recognition for the field:

1. American College of Lifestyle Medicine (ACLM)

Description: ACLM in the primary professional medical society dedicated to LM and leads research, education, advocacy, and certification efforts to establish LM as a mainstream, evidence-based specialty. As of 2024, ACLM had 13,500 members in various healthcare professions.
https://lifestylemedicine.org/about-aclm/

Policy Influence: In June 2024, ACLM was inducted into the AMA House of Delegates, granting them a voice in shaping U.S. healthcare policy and amplifying the push for LM recognition.
https://www.prnewswire.com/news-releases/american-college-of-lifestyle-medicine-announces-induction-into-the-american-medical-association-house-of-delegates-302168585.html

2. American College of Preventive Medicine (ACPM)

Focus & Partnership: ACPM is a long-established preventive medicine society, with over 2,000 members. https://acpm.org/about/

ACPM co-led a national consensus panel with ACLM to define core competencies in Lifestyle Medicine, which were published in JAMA. These competencies form the foundation of the LM Core Competencies (LMCC) Program, a continuing medical education curriculum that provides a comprehensive introduction to the foundational principles of LM. https://www.acpm.org/initiatives/lifestyle-medicine

Education & Advocacy: ACPM has also developed a strategic roadmap for the integration of LM and preventive medicine core-competencies into the foundational curriculum of undergraduate medical education to better prepare future physicians to help their patients maintain wellbeing, reduce healthcare costs, and improve care quality.
https://www.acpm.org/initiatives/lifestyle-medicine

3. National Board of Physician Nutrition Specialists (NBPNS)

Credentialing Specialty Overlap: NBPNS (not to be confused with NBPAS) is a credentialing body certifying physicians in nutrition medicine. Its mission overlaps significantly with LM through shared emphasis on nutrition as a root cause intervention. NBPNS includes physicians certified by ABMS Member Boards who possess additional training or extensive clinical experience in nutrition therapy. There are currently over 200 NBPNS-certified physician nutrition specialists.
https://nbpns.org/

4. American Association of Clinical Endocrinology (AACE)

Relevance Through Clinical Domain: AACE is the leading membership society focusing on endocrinology. With endocrinology's close links to metabolism, obesity, and nutrition it is inherently tied to Lifestyle Medicine interventions. Though not explicitly advocating for a LM certification, its domain overlaps suggest a vested interest in related professional credibility. AACE has over 5,900 endocrine-focused clinical members.
https://www.aace.com/disease-and-conditions/nutrition-and-obesity
https://pro.aace.com/about/about-american-association-clinical-endocrinology

5. Ardmore Institute of Health (AIH)

Founded in 1947, AIH's mission is to "improve the health and vitality of people to live more meaningful lives," which it accomplishes through patient programs, grants to mission-aligned non-profits, and research and collaboration with health professionals. Its Full Plate Living program is offered free of charge to thousands of people and helps patients prevent and reverse chronic disease by emphasizing the principles of lifestyle medicine and whole-person care.
https://www.ardmoreinstituteofhealth.org/

6. American College of Occupational and Environmental Medicine (ACOEM)

With over 4,500 members, ACOEM represents Occupational and Environmental Medicine physicians and other healthcare professionals. It is dedicated to promoting the health of workers through preventive medicine, clinical care, research, and education and is a long-standing preventive medicine specialty society.
https://acoem.org/About-ACOEM

iv. Indicate the nature of the relationship of the national societies' membership with the proposed FPD:

Why These Societies Matter

ACLM: ACLM is the central hub for LM, both in membership and strategic activities. With over 13,500 members globally, including roughly 7,000 certified professionals, ACLM is LM's main professional society, and a driving force for the growth of lifestyle-based care under the banner of LM.

ACPM: With nearly 2,000 members, and ABPM's current national specialty society for Preventive Medicine, ACPM adds credibility by embedding LM into preventive medicine, including education and rigorous standards.

NBPNS: While smaller and more specialized, NBPNS overlaps substantially in terms of nutrition-focused clinical competencies and represents established nutrition credentials that could integrate or intersect with an FPD in LM.

As a certifying body for physicians in nutrition medicine and affiliated with several major nutrition and obesity societies, NBPNS has established credentialing standards and administers examinations for physician nutrition specialists.

AACE: AACE's membership base in metabolic disciplines represents a potentially strong advocacy group for LM. By covering obesity and metabolic disease, AACE will stand as a key stakeholder in adopting lifestyle-focused practice frameworks.

AIH: AIH's mission is to "improve the health and vitality of people to live more meaningful lives," which it accomplishes through patient programs, grants to mission-aligned non-profits, and research and collaboration with health professionals, all of which are based on the pillars of lifestyle medicine.

ACOEM: ACOEM's mission is to promote optimal health and safety of workers, workplaces, and environments by advancing the specialty of occupational and environmental medicine. As a long-standing preventive medicine society, ACOEM's emphasis on prevention of illness and injury align with lifestyle medicine principles. ACOEM provides guidance and education to physicians on implementing lifestyle medicine interventions in workplace settings. https://acoem.org/Guidance-and-Position-Statements/Guidance-and-Position-Statements/Incorporating-Lifestyle-Medicine-into-Occupational-Medicine-Practice

9. Please describe how the cognitive knowledge, clinical and interpersonal skills, professional attitudes, and practical experience of diplomates in this proposed FPD will be distinct from diplomates in other specialties, subspecialties, and FPDs in terms of (include information where there is overlap):

a. Clinical Competence

The clinical competence of an LM practitioner is distinct from that of diplomates in other specialties. LM goes beyond recommending healthy habits: it requires specialized knowledge in prescribing, monitoring, and adapting therapeutic lifestyle changes across complex populations.

LM practitioners are trained to evaluate and address root causes of disease across systems. Their cognitive focus is diagnosis-agnostic, enabling them to treat multiple conditions concurrently by targeting shared behavioral and environmental contributors.

Chronic conditions like hypertension, hyperlipidemia, type 2 diabetes, and fatty liver disease often co-occur and stem from shared behavioral pathways. LM training emphasizes the interconnected pathophysiology and behavioral origins of these conditions (Panagiotakos et al., 2006). This distinguishes LM from most specialties that address disease in organ-based silos.

LM cognitive competencies include understanding macronutrient profiles, micronutrient sufficiency, nutrient-disease interactions, meal planning, and personalized nutrition strategies based on chronic disease status (Kahleova et al., 2017; Barnard et al., 2009). The process for achieving an FPD in LM will include several hours of rigorous, case-based nutrition education grounded in peer-reviewed evidence. This depth of nutritional expertise exceeds the brief exposure in most U.S. medical education curricula, where physicians receive fewer than 20 hours of nutrition instruction on average (Adams et al., 2010).

A unique domain of LM knowledge lies in clinical implementation of lifestyle programs, team-based care models, and population-based strategies. Practitioners understand intensive behavioral therapy for obesity and cardiovascular risk, group visit models, and shared medical appointments (SMA). They are skilled in leading interdisciplinary teams including dietitians, psychologists, health coaches, and exercise specialists. This practical systems knowledge is not commonly taught in conventional residency or fellowship programs but is essential for scalable, cost-effective care delivery (Eaton et al., 2015).

Perhaps the most cognitively distinctive feature of LM is its focus on disease reversal, not just management. This requires:

- Familiarity with longitudinal cohort studies and reversal trials
- Ability to interpret and apply evidence in high-risk patients (e.g., T2D remission, NAFLD resolution)
- Knowledge of titrating medications downward ("deprescribing") as health improves, an unfamiliar process to many specialists
- Therapeutic nutrition, particularly whole-food, plant-predominant dietary patterns and their application in disease reversal (Kahleova et al., 2017; Barnard et al., 2006)
- Interactions between lifestyle factors and gene expression, inflammation, and metabolic disease (Ornish et al., 2008)
- Pathophysiology of lifestyle-related diseases and the evidence supporting disease remission through behavior change (Lean et al., 2018; Ornish et al., 1998)

- Behavioral change science, including motivational interviewing, health coaching, and the transtheoretical model (Miller & Rollnick, 2013)
- Clinical application of exercise, sleep, stress management, and psychosocial support for disease management (Egger et al., 2020)

Specialists like general internists, and family and emergency physicians generally focus on disease management with interventions that support the immediate reduction in symptoms of illness, the inclusion of patient-centered communication strategies, advanced therapeutic tools, and disease reversal frameworks is limited. The focus on sustainable lifestyle change and disease reversal is the common therapeutic goal of the multi-disciplinary team utilized by LM physicians.

b. Scope of Practice

LM practitioners embody a systems-aware mindset focused on addressing root causes of disease, health equity, and long-term wellness. Their professional values include:

- Prioritizing patient agency and shared goal setting
- Advocating for health promotion at the population level
- Embracing interdisciplinary collaboration rather than hierarchical care
- Redefining success not only as disease control, but as functional restoration and quality of life

While many specialties focus on managing pathology, LM cultivates a mindset that health is a resource to be restored, not just disease to be controlled. LM physicians are trained to value reversal, resilience, and restoration as achievable outcomes.

LM training involves **hands-on clinical application** of lifestyle prescriptions, including:

- Leading or participating in **structured lifestyle intervention programs**
- Coordinating care across **multi-disciplinary teams** (e.g., dietitians, therapists, exercise physiologists)
- Monitoring outcomes to **deprescribe medications** safely as health improves
- Managing **group visits, virtual care models**, and community-based health promotion

Unlike most physicians who gain procedural, pharmacologic, or diagnostic experience, LM physicians gain **real-world practical experience** in implementing, adapting, and scaling therapeutic lifestyle plans. Their scope includes not only disease treatment but **programmatic delivery and systems transformation**.

Professional Attitudes

LM practitioners embrace a root-cause mindset, including:

- Viewing chronic disease as modifiable and often reversible
- Championing systems-level change in clinical settings, public health, and policy
- Promoting health equity through lifestyle interventions that address social determinants of health.

c. Body of Knowledge and Skills

LM diplomates gain applied training in real-world clinical settings by:

- Leading or participating in (intensive) therapeutic lifestyle programs (e.g., Ornish, Pivio. (formerly known as CHIP), Lift, Full Plate Living, or Pritikin)
- Implementing group-based care models
- Developing care plans that involve deprescribing medications as health improves (Lim et al., 2011)
- Managing comorbid chronic conditions through unified lifestyle prescriptions rather than disease-specific silos

Other specialties may gain experience in multidisciplinary teams or community settings, but they do not engage in structured, hands-on application of lifestyle as a comprehensive, integrative therapy.

LM practitioners possess a unique cognitive foundation that emphasizes the therapeutic use of lifestyle interventions as evidence-based, first-line treatments to prevent, treat, and reverse chronic diseases.

- **Clinical nutrition** with advanced understanding of plant-predominant dietary patterns and their role in chronic disease reversal
- **Exercise physiology** tailored to the management of metabolic, cardiovascular, and musculoskeletal conditions
- **Sleep science**, including behavioral and environmental contributors to sleep dysfunction
- **Stress physiology and resilience science** as medical treatment targets
- **Behavioral psychology** applied to lifestyle change and motivational interviewing
- **Health systems knowledge**, including the delivery of lifestyle programs in primary care, digital health, and group settings.

Although the subspecialty of Sleep Medicine covers one of the six pillars of lifestyle medicine, it does not incorporate the other five domains. The depth and integration of cognitive knowledge across multiple health domains is not included in any other specialty training, making LM diplomates distinct in their intellectual framework and therapeutic approach.

Clinical and Interpersonal Skills

LM practitioners are trained to deliver care through relational, behavior-focused clinical models. Their patient encounters are grounded in facilitating change, not just conveying information or prescribing medications.

Distinctive Skills:

- Motivational interviewing and shared decision-making as default tools in clinical interaction
- Conducting group visits and shared medical appointments
- Collaborating in interprofessional care teams, including health coaches, dietitians, and fitness professionals
- Assessing readiness for change, co-developing action plans, and navigating ambivalence
- Deprescribing medications safely and systematically as health improves

These skills differ markedly from most clinical specialties, which emphasize diagnosis and treatment of disease rather than sustained, behavior-driven transformation of patient health.

Professional Attitudes

LM practitioners adopt a root-cause, patient-centered, and population-aware mindset. Their professional orientation focuses not only on individual care but also on health equity, prevention, and long-term healing.

Distinctive Attitudes:

- A belief that chronic disease is largely preventable and often reversible
- A commitment to collaborative, non-hierarchical care models
- A focus on patient agency, self-efficacy, and empowerment
- An orientation toward systemic change: improving food environments, workplaces, and communities
- Dedication to role modeling healthy behaviors and creating cultures of health within organizations

These values are distinct from the treatment-oriented attitudes of most specialties, where professional identity often centers around symptom management and procedural care.

LM physicians gain practical, hands-on experience in the design, delivery, and monitoring of therapeutic lifestyle plans. Their training includes real-world application of clinical and population-based LM interventions.

Distinctive Practical Experience Includes:

- Prescribing and managing lifestyle-based treatment plans for patients with diabetes, cardiovascular disease, and obesity
- Leading or participating in intensive therapeutic lifestyle change programs (e.g., CHIP, Ornish, Pritikin, PLMI)
- Deprescribing medications based on lifestyle-induced improvements in health markers
- Running or contributing to shared medical appointments and community-based lifestyle programs
- Implementing LM interventions in primary care, digital health, corporate wellness, or faith-based settings

Unlike most physicians, whose practical experience is procedural, pharmacologic, or diagnostic in nature, LM practitioners develop deep expertise in real-world behavior change interventions that target upstream drivers of disease.

The body of knowledge and skills held by LM practitioners is clearly differentiated from those in other specialties. LM practitioners are not simply generalists with an interest in healthy behaviors; they are specialists in delivering, monitoring, and leading evidence-based lifestyle interventions as core therapeutic tools.

Their training includes:

- A distinct cognitive knowledge base
- Unique clinical and interpersonal competencies
- A values-based, prevention-oriented professional attitude
- Practical experience in the implementation of lifestyle interventions at the individual and population level

If there is a potential area of overlap, please describe how.

10. For (a) through (e) below, please project the need for and the effect of the proposed FPD on the existing patterns of certification or other FPDs. Please indicate how you arrived at your response.

    a. Please describe the impact of the proposed FPD on practice, both existing and long-term, specifically:

i. Access to Care

The FPD in LM will expand patient access to preventive and therapeutic care for chronic disease by recognizing and credentialing a distinct clinical skill set that is currently underutilized in mainstream medicine. This designation will formalize a pathway for physicians in any specialty to deliver evidence-based lifestyle interventions, increasing the pool of qualified providers equipped to address root causes of disease.

Chronic conditions such as heart disease, diabetes, obesity, and hypertension affect both adults and children with those conditions, impacting over 60% of adults in the U.S. (CDC, 2023). However, fewer than 15% of practicing physicians report feeling adequately trained to counsel patients on nutrition, physical activity, and behavior change (Adams et al., 2010). The proposed FPD would:

- Empower primary care, internal medicine, and specialty physicians to expand their scope of service without needing to fully retrain in a new specialty
- Incentivize more physicians to pursue this training
- Support the adoption of team-based models (e.g., shared medical appointments), multiplying provider capacity

By credentialing LM expertise within existing specialties, the FPD will rapidly expand patient access to lifestyle-based care without requiring the development of new clinics or departments.

ii. Quality and Coordination of Care

This FPD will elevate the quality and coordination of chronic disease care by emphasizing root-cause treatment, behavior change facilitation, and interprofessional collaboration. LM practitioners are particularly effective in coordinating care across disciplines such as nutrition, behavioral health, and pharmacy, which is critical for complex chronic cases.

- LM-trained physicians reduce medication load, hospitalizations, and progression of disease, improving quality metrics such as HEDIS and Medicare STAR ratings (Ornish et al., 1998; Lim et al., 2011).

- LM practitioners are trained in deprescribing and transitions of care, which improves safety and reduces polypharmacy.
- The group-visit model widely used in LM has been shown to improve adherence, patient satisfaction, and continuity (Eaton et al., 2015).
- LM frameworks align with current value-based payment models, which reward preventive, coordinated care (CMS, 2022).

This FPD would catalyze the integration of LM into existing systems, creating a bridge between disease prevention and treatment while reducing care fragmentation.

iii. Benefits to the Public

The LM FPD will directly improve public health outcomes by accelerating the shift from disease management to disease reversal and prevention—an approach aligned with the CDC's and WHO's long-term strategies for noncommunicable disease control.

- Up to 80% of chronic disease burden is preventable through lifestyle changes (Ford et al., 2009).
- Intensive lifestyle interventions have demonstrated reversal of coronary artery disease (Ornish et al., 1998), type 2 diabetes (Lean et al., 2018), and early-stage hypertension (Appel et al., 1997).
- LM reduces costs for patients and health systems. For example, the Ornish Program is reimbursed by Medicare due to its cost-saving outcomes (CMS NCD #20.31).
- Public trust and engagement improve when clinicians provide hopeful, empowering, non-pharmacologic options.

As a formally recognized FPD, LM will greatly assist in closing the gap between what is known in the literature and what is practiced in clinical settings, bringing proven benefits to a broader patient population.

i. Both immediate and long-term costs and their relationship to the probable benefits (please indicate your methodology)

Immediate Costs

Administrative & Development Costs

- Receiving COCERT approval which requires the creation of standards, eligibility criteria, and governance structures.
- Convening expert panels, stakeholder consultations, and public comment processes.
- Legal review and updates to governance documents to ensure alignment with ABMS, ACGME, etc., policies requirements.

Operational & Implementation Costs

- Exam design and validation/psychometric analysis
- Development and implementation of CCP Requirements
- Technology and IT design updates to manage applications, registrations and results

Marketing & Communication Costs

- Outreach to payers and policymakers to recognize the FPD in LM
- Educating physicians, healthcare systems, and the public on the value of the FPD in LM

Immediate Benefits

Formal ABMS recognition of physicians already practicing LM and thereby increasing professional legitimacy.

Enhanced credibility with healthcare systems, payers and policymakers (federal/state/local governments)

Healthcare delivery costs will likely decrease with early access to appropriately trained providers which can, in turn, reduce the costs associated with nonintervention.

Long-Term Costs

Sustainability & Maintenance

- Ongoing exam updates and content revision
- Monitoring of physician compliance with CCP
- Broadening eligibility across ABMS Boards Community
- Conducting periodic Practice Analysis to properly align with evolving scientific evidence

Opportunity Costs

- Diversion of resources from other certification initiatives
- Risk of slower adoption if physician, healthcare system, governmental or public interest does not grow as projected

Long-Term Benefits

- Expanded pool of ABMS Member Board physicians dedicated to prevention and chronic disease management.
- Reduced long-term costs through improved patient outcomes (e.g., diabetes remission, cardiovascular risk reduction).
- Growing patient interest in LM interventions creates strong demand for credentialed experts.
- A recognized FPD in LM may assist in securing insurance reimbursement for LM interventions.
- Physicians gain a career-enhancing credential, strengthening recruitment into preventive and primary care specialties.

In summary, establishing an FPD in LM will likely require substantial upfront investment (governance, exam development, marketing, etc.), with benefits primarily in legitimacy and professional recognition in the short run. Over time, however, as adoption of the credential grows and payers/policymakers recognize the credential, the benefits—both in physician workforce growth and public health impact will likely significantly outweigh the costs.

ii. Long-term costs and their relationship to the probable benefits (please indicate your methodology):

See ABPM's response to Item (i), immediately above.

b. Please explain the effects if this area of focused practice is not approved:

If the American Board of Medical Specialties (ABMS) Committee on Certification (COCERT) or its Board of Directors were to deny the approval of an FPD in LM, it would have several important effects across various domains: professional recognition, patient care, and healthcare innovation. A summary of those effects are as follows:

1. Professional Recognition and Career Impact

Effect:
Physicians specializing in LM would lack formal ABMS recognition, which affects their credibility, legitimacy, and career advancement.

Details:
LM practitioners would not be able to claim an ABMS-recognized credential in LM, thereby limiting their ability to differentiate themselves professionally.

Employers, academic institutions, and insurers often place high value on ABMS board credentials when evaluating qualifications.

This could discourage physicians from pursuing or specializing deeply in LM if it lacks comparable professional status.

2. Training and Standardization

Effect:
There would be no unified standard for competency or training in LM under ABMS.

Details:
Without an FPD in LM, there's no formal pathway to ensure standardized curricula, training requirements, or certification exams in LM. This could lead to variability in the quality and scope of practice among providers who claim expertise in the field.

3. Reimbursement and Policy Support

Effect:
Lack of ABMS recognition may limit insurance reimbursement and policy support for LM-based interventions.

Details:
Payers may not recognize LM interventions as legitimate or reimbursable care pathways without a recognized medical specialty or FPD. Therefore, policymakers and healthcare systems may be less likely to integrate or prioritize LM into public health and chronic disease management strategies.

4. Impact on the Growth of the Field

Effect:
Denial of a FPD in LM would likely slow the growth and institutional adoption of LM as a mainstream medical discipline.
Details:
Academic medical centers might deprioritize development of fellowships, departments, or research initiatives without ABMS recognition. Furthermore, medical students and residents may avoid the field due to the lack of a clear, recognized career pathway.

5. Alternative Certification Pathways Would Continue

Effect:
The American Board of Lifestyle Medicine (ABLM) and international bodies would continue to offer non-ABMS certifications.

Details:
While these certifications may grow in popularity, they would still lack the authority and widespread acceptance that comes with ABMS recognition.

This creates a two-tier system of certification, which could confuse patients and stakeholders about qualifications.

6. Patient Access and Outcomes

Effect:
Ultimately, the denial could limit patient access to evidence-based lifestyle-based interventions, despite their proven efficacy in managing chronic disease.

Details:
Fewer physicians may be trained or motivated to integrate lifestyle-based approaches. Patients may continue receiving primarily pharmacological or procedural treatments instead of holistic, prevention-focused care.

11. Please indicate how the proposed FPD will be evaluated periodically (e.g., every five years) to ensure that the area of focused practice remains viable:
    a. Please outline plans for evaluation of the impact of the proposed FPD on your own Board's and other Member Boards' programs of specialty and subspecialty certification and any other areas of focused practice:

The FPD in LM will be evaluated three years after the inaugural administration of the assessment examination to ensure that the FPDs goals have been accomplished. During that initial review, ABPM will also evaluate and confirm that the interest and trajectory of those seeking to achieve an FPD in LM remains economically viable for the then-foreseeable future.

Separately, every five years, ABPM will conduct an analysis of the data for those seeking to achieve an FPD in LM. The analysis and corresponding research will assist ABPM in determining; (i) where the most/least interest resides among the other 23 ABMS Member Boards, (ii) what gaps may exist in underlying training and (iii) what updates, changes or revisions to training are necessary to support physician practice in the LM arena. ABPM intends to share the analysis and seek input from all ABMS

Member Boards to perpetually enhance and improve the FPD in LM and further, to allow the Member Boards Community the opportunity to include such findings within the various practice analyses that will inform further content outlines/blueprints for all ABMS Member Board certified physicians.

12. Please list key stakeholder groups from which ABMS may wish to solicit commentary on the proposed FPD:

ABMS Member Boards:
American Board of Family Medicine
American Board of Internal Medicine
American Board of Psychiatry and Neurology
American Board of Pediatrics
American Board of Emergency Medicine

Medical Specialty Societies:
American College of Lifestyle Medicine
American College of Preventive Medicine
American Academy of Family Physicians
American College of Physicians
American Medical Association

Patient & Public Health Organizations:
Patient Advocacy Groups
Public Health Departments and Community Organizations
CDC's Division for Heart Disease and Stroke Prevention
American Heart Association
American Diabetes Association
National Institute of Health

N/To be completed for proposed FPDs for which formalized training is currently available to meet some of the requirements for clinical experience and patient volume:

13. Please provide the following information for those training programs that have a primary educational effort devoted to the proposed FPD, along with their geographic locations and the source(s) of the data:

    a. Please list the names of training programs in the proposed FPD:

       Loma Linda University in Loma Linda, CA

    b. Indicate the total number of trainee positions available currently (along with the source(s) of the data):

       Per Program Director, Dr. Karen Studer, the Loma Linda program hosts two fellows each year. Further, the LMRC Growth and Certification Outcome Data is outlined in Section (c), below.

    c. Provide the number of trainees completing the training annually (along with the source(s) of the data):

       LMRC Growth and Certification Data: 2018-2024 is included on the following chart.

Lifestyle Medicine Residency Curriculum (LMRC) Growth and Certification Outcome Data: 2018-2024

	2018	2019	2020	2021	2022	2023	2024
LMRC Site and Program Growth Data							
Number of Sites	4	8	17	49	99	135	170
Number of Programs	7	13	29	82	204	304	368
Individual ABLM Certification Outcome Data							
Number of Exam Registrants	Data Unavailable					59	~109*
Number of Exam Registrants Certified	Data Unavailable			4	11	55	~105*
Exam Certification First Time Pass Rate	Data Unavailable					93%	~96%*

* Values marked with '~' are approximate estimates

d. Organization(s) providing accreditation or oversight for training programs (Please submit evidence that they have the willingness, capability, and resources to conduct the review of these programs):

The Lifestyle Medicine Graduate Medical Education Council (LMGMEC), using subject matter experts will review and approve educational requirements for those seeking to become eligible to sit for ABPM's assessment examination in LM.

14. How much additional clinical experience is required beyond training?

No additional clinical experience will be required of those physicians completing the Loma Linda University program in LM.

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Proposed Eligibility Criteria — Lifestyle Medicine Focused Practice Designation

Overview / Prerequisites (applies to all pathways)

- Hold active certification from an ABMS Member Board (primary board), e.g., American Board of Preventive Medicine (ABPM) or another qualifying ABMS Member Board, and be in good standing at the time of application and throughout maintenance of the FPD.
- Be current in the primary board's Continuing Certification (CC) program at the time of application and throughout FPD maintenance.
- Hold an unrestricted medical license in the U.S. or Canada as required by the administering board's policy on medical licensure.
- Provide an application and fee (procedural language to be set by the administering board).

Three Authorized Eligibility Pathways

A. Non-ACGME Fellowship Pathway

- Successful completion of the fellowship requirements as outlined below:
  - Successful completion of an ABPM-approved Lifestyle Medicine fellowship or training program of minimum 12 months (non-ACGME) OR successful completion of an ABPM-approved longitudinal training program that is judged equivalent.
  - Submit a Case Log from the fellowship demonstrating supervised LM clinical encounters.
- Verification: Written attestation from fellowship program director.

B. ABPM Lifestyle Medicine Practice Pathway

- Successful completion of practice requirements as outlined below:
  - Demonstrate at least 24 months of LM-focused practice within the 60 months immediately preceding application, with a minimum average of 10 hours/week devoted to LM patient care, education, leadership, or supervision.
  - Complete the Clinical Practice Experience requirements as outlined in Section 5(b) of the application.
  - Completion of Case Log Submission for patient interactions within the 60 months immediately preceding application (See Case Log Submission Requirements below)
- CME Requirement: 30 or more hours of ABPM-approved LM CME over the 24 months immediately preceding application
- Verification:
  - Demonstration of Current Practice: Letter from supervisor (or equivalent) confirming completion of Clinical Practice Experience.

C. ABLM Pathway

- Successful completion of practice requirements as outlined below:
  - At the time of application, be certified and in good standing with the ABLM
  - Demonstrate continued and current LM practice
    - Acceptable LM practice activities include: direct LM clinical care, leadership/medical director roles for LM programs, LM curriculum leadership, precepting of LM trainees, or system-level LM program development.
  - Completion of Case Log Submission (See Case Log Submission Requirements below) for patient interactions within the 60 months immediately preceding application
- CME Requirement: 30 or more hours of ABPM-approved LM CME over the 24 months immediately preceding application
- Verification:
  - ABLM Certification: Written confirmation of certification provided by ABLM.
  - Demonstration of Current Practice: Letter from supervisor (or equivalent) confirming dates and responsibilities. Board may request job description, org chart, or CV

Case Log Submission

- Submit a case log with a minimum of four disease reversal/remission cases (weight loss, T2D remission, hyperlipidemia improvement, hypertension remission).
- Each case must include: date of encounter; patient age/sex (de-identified); primary diagnoses; LM interventions used; objective baseline and outcome measures; role of the applicant; evidence of follow-up.
- Applicants who are certified by ABLM and current with ABLM's continuing certification program at the time of application may be eligible to have case-log/time requirements reduced or waived.

Additional Qualifications / Professionalism

Applicants must comply with ABPM's Policy on Medical Licensure and Code of Professionalism.

Continuing Certification & Maintenance

- Diplomates holding the LM FPD must remain current in their primary board CC program and meet LM FPD CC requirements (e.g., LM-focused LAP, CME and at least one IHHC for each 5-year FPD cycle).
- Diplomates must attest annually that their practice remains focused on LM.
- The LM FPD will be evaluated by ABPM 3 years after establishment and at 5-year intervals thereafter.

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