

Consensus Statement/ Position Statement

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Lifestyle Medicine Core Competencies: 2025 Update

Abstract: Lifestyle medicine (LM) competencies are necessary to outline the knowledge and skills required to become certified and practice evidence-based LM across various medical and health care professional disciplines. The earliest LM competencies were published for physicians in 2010 with an expansion of competencies in 2015 to include additional competencies relevant to physicians as well as a variety of other health care professionals, followed by a 2022 LM Competency update. As the global LM priorities evolved, the Lifestyle Medicine Global Alliance (LMGA) commissioned a review of the current competencies by the LMGA Scientific Advisory Committee. This resulted in two minor updates to the already existing planetary health and food processing competencies and the addition of a new competency to address social determinants of health (SDOH). This brought the total number of competencies from 88 in 2022 to 89 in 2025. As the field of LM continues to grow and organize globally, the need to create a structure

for LM competency updates became evident. This article summarizes the competency updates and outlines the implementation schedule for future competency updates.

Keywords: lifestyle medicine; competencies; chronic disease treatment; lifestyle medicine global alliance; medical education

Introduction

Lifestyle medicine (LM) competencies are necessary to define the knowledge and skills required to practice evidence-based LM across various international medical and health care professional disciplines with the goal of chronic disease treatment, prevention, and reversal. In addition, these competencies form the basis for the Lifestyle Medicine Physician certification exam offered by the International Board of Lifestyle Medicine (IBLM). LM core competencies for physicians were originally published in the Journal of

the American Medical Association (JAMA) in 2010. In 2020, oversight of LM competencies transitioned from the American Board of Lifestyle Medicine (ABLM) to the Lifestyle Medicine Global Alliance (LMGA), an affiliate of the IBLM. As the field of lifestyle medicine advanced, updated competencies relevant to physicians and other health care professionals were developed and published in 2022. Following the Global LM Leadership Forum in Doha, Qatar, in 2024, LMGA established the LMGA Scientific Advisory Committee (SAC)—comprising experts from diverse regions within LMGA—to update the competencies and determine a schedule for future revisions. This SAC led the latest revision of the LM Core Competencies.

Objectives

The objective of this article is to present the results from the review of the previous competencies by the SAC and to outline the update schedule for future revisions of the competencies.

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Methods

This consensus update of the competencies was adapted from an a priori protocol (previously developed by AAO-HNSF¹ and also used by ACLM to develop expert consensus statements), modified to streamline the process.

Disclosure of potential conflicts of interest were reported and vetted. No direct conflicts of interest existed for the chair or panel members. The project chair led the development of the revisions and the Delphi process with administrative support from the American College of Lifestyle Medicine (ACLM) staff.

Discussion and Editing of Competencies for Delphi Voting

Informed by the directive from LMGA and led by the chair, a full competency review was completed by the SAC. Panel members drew from their used expert opinion and stakeholder needs to consider edits to previously published LM Core Competencies. Suggested areas to address included adding a competency related to social determinants of health (SDOH) and revising the competencies related to planetary health and processed foods. Consensus was reached in the first meeting of three meetings to contain the update process to these three topics, as well as develop an update schedule for future revisions. A survey was disseminated following the first meeting to gather free-text feedback on considerations for developing an update schedule, as well as use Delphi survey questions, described below, to assess their agreement regarding edits to the competencies related to planetary health and food processing, as well as creation of a new competency on social determinants of health (SDOH). Suggested verbiage for updates and placement was collected.

In the second meeting, results from the first survey were discussed and preliminary agreement was reached about the verbiage for the new competency and two edited

competencies, as well as the update schedule. This was confirmed using a Delphi survey sent following the second meeting.

In the third meeting, the results from the second survey were discussed (full agreement), and writing assignments were confirmed by the chair to develop the publication.

Competencies were developed or modified to follow best educational practices in developing learning objectives, using a strong action verb to begin each statement.

Delphi surveys used were created by ACLM staff as needed, with oversight from the chair. An online research survey platform (<https://www.questionpro.com/>) was used to administer the surveys to SAC panelists.

Questions in the survey were answered with a 9-point Likert scale, with anchors of 1 = strongly disagree, 3 = disagree, 5 = neutral, 7 = agree, and 9 = strongly agree. The surveys were distributed, and responses were analyzed and presented in the next meeting. Statements or edits that achieved near consensus were discussed further and revised for re-voting.

The final draft of the revised competencies manuscript was developed with contributions from each panel member and editing/oversight from the chair and ACLM staff.¹

Criteria for Consensus Were Established a Priori as Follows

Consensus: Statements achieving a mean score of 7.00 or higher and having no more than 1 outlier, defined as any rating 2 or more Likert points from the mean in either direction.

Near Consensus: Statements achieving a mean score of 6.50 or higher and having no more than 2 outliers.

No Consensus: Statements that did not meet the criteria for consensus or near consensus.

The final manuscript was reviewed and approved by LMGA, IBLM, and ABLM.

Summary of Competency Updates

A review of the current competencies resulted in two minor updates to the already existing competency on planetary health (Introduction Section, competency 8 – A8) and the food processing competency (Nutrition Section, competency 5 – C5), as well as the addition of a new competency to address social determinants of health (placed in the Introduction Section as competency 9 – A9).

New Competency A9

Apply LM interventions in the context of social determinants of health (SDOH) to improve health outcomes and health equity.

SDOH are drivers of up to 50% of health outcomes.² Despite this, traditional medical training often lacks a comprehensive approach to address these factors.³ This new competency was added because LM offers a valuable framework for mitigating the deleterious effects of SDOH and can empower health care professionals to drive systemic change.⁴

SDOH will often be invisible to the practitioner (unless specific information is obtained from the patient related to them). Therefore, a practitioner must focus on the development of skills, knowledge, attitudes and values needed to integrate SDOH into LM effectively in professional and social contexts.⁵ Such a focus may include assessment of a patient's social and economic environments, interventions designed to be culturally relevant and effective collaboration with interdisciplinary teams and communities. Collaborative approaches that engage communities and empower patients are critical to creating

sustainable change.⁶ As a result, this new competency is intended to alert practitioners to the importance of tailoring LM interventions to accommodate, and perhaps even to integrate with, the social, cultural, structural and political drivers which affect any given individual.

By integrating SDOH into LM training, all health care professionals will be better equipped to address inequities and promote health equity, fostering a comprehensive approach to care that meets the needs of patients and communities. Furthermore, by developing competency in delivering SDOH-informed LM interventions, patients' health care needs are much more likely to be met. These SDOH-based interventions not only improve physical and mental health,⁷ but also strengthen people's functional capacity and resilience.²

The development of "chef-coaching"⁸ represented an early effort to develop an SDOH-informed LM practice. SDOH-informed practices across all pillars of lifestyle medicine must be implemented for more widespread equity and improved outcomes. Such efforts could include supporting patients to connect with resources for housing and local environmental improvements (also see Updated Competency A8); positively promoting group exercise and/or community volunteer programs; supporting and encouraging workplace well-being programs; supporting patients to navigate health care systems and supporting patients to connect with resources for financial support as required.

Research and policy advocacy can highlight the effectiveness of LM interventions and support their adoption as an educational and clinical standard.⁹ The impact of SDOH-informed LM practices on reducing inequities, by promoting their inclusion as an educational and clinical standard, will ensure that professionals are prepared to

comprehensively care for their patients in diverse real-world contexts.

Updated Competency A8

2022 Competency A8: Explain the impact of lifestyle choices on planetary health and sustainable living.

2025 Updated Competency A8: Examine the relationship between LM, planetary health, and sustainable living.

The A8 competency was updated to emphasize the bidirectional nature of the relationship between human and planetary health and second, as well as to emphasize the health consequences and the scientific evidence supporting the relationship.

Climate change and air pollution lead to an emerging number of adverse effects regarding human health, including premature mortality.¹⁰ Air pollution, through pollutant toxicity or inflammation, not only impacts respiratory health but is also a risk factor for cardiac symptoms and other organ dysfunction as well.¹¹ As plants produce more pollen in the presence of excess carbon dioxide, allergies become more frequent and severe.¹² Besides the obvious dangers, asthma attacks become more severe following extreme atmospheric events such as heat waves, droughts, thunderstorms, floods, cyclones and hurricanes.¹³ The World Health Organization declared climate change to be "the single biggest health threat facing humanity in 2021."¹⁴

Similarly, human activities and lifestyle choices affect our planet. Food choices are clearly linked to health outcomes, but dietary patterns are also drivers of planetary health. This impact can be measured by carbon dioxide emissions which come from human activity such as transportation and food production. A high consumption of animal-based products, particularly ruminant meat, is reported to be the chief factor contributing to high carbon footprints.¹⁵ Predominantly plant-

based diets on the other hand are shown to carry low carbon footprints with reduced production of harmful greenhouse emissions.¹⁵

Poorly disposed plastics are an additional threat to the planet. Micro plastics contribute to marine water pollution, potentially leading to chemical toxicity and change in behavior of aquatic life with cascading effects on the marine food chain.^{16,17} Exposure to endocrine disrupting chemicals (EDCs), commonly found in plastics, pesticides and fungicides have the potential to disrupt reproductive processes in wildlife. This can potentially destabilize the ecosystem balance.^{18,19} This can be averted through eco-friendly practices that reduce exposure to plastics, pesticides, fungicides and other toxic chemicals.

A redefined emphasis on the bidirectional relationship between human and planetary health as well as the health consequences of such a relationship, including in the context of the built environment and urban green spaces,^{20,21} brings into focus the need for LM practitioners to address these issues on an ongoing basis.

Updated Competency C5

2022 Competency C5: Describe how the level of processing in a food affects health and discuss the evidence base for these effects.

2025 Updated Competency C5: Appraise the evidence base related to how the level and type of food processing affects health outcomes

The competency was updated to reflect the significant impact modern food processing can have on the nutritional quality of food. It is essential for health care professionals to comprehend how processing techniques can affect the nutritional value of food and its association with chronic disease. This knowledge enables health care providers to effectively guide patients to select foods that support the prevention and treatment of chronic disease, thereby

improving overall patient health outcomes.

There are several Ultra Processed Food (UPF) classification systems available, with each having areas of strengths and weaknesses.²² Variability in the classification systems for categorizing the level of food processing is still a challenge when studying the quality of a diet and the associated health outcomes.²² However, the most widely used system is the NOVA classification system that was established in 2010, which categorizes food into 4 categories of processing: minimally processed food or unprocessed, processed culinary ingredients, processed foods, and ultra-processed foods (UPFs).²³ Ultra-processed foods (UPFs) have become increasingly prevalent in the modern diet globally, contributing significantly to various adverse health outcomes.²⁴ UPFs are typically highly palatable, non-nutritious, energy-dense food-like products providing high calories from saturated fats, refined grains, low fiber, and added sugars while also containing a myriad of artificial ingredients and preservatives.²³ The convenience and affordability of these foods have made them quite popular,^{24,25} but their negative impact on health cannot be ignored.

A large body of evidence is emerging showcasing the association of UPFs with an increased risk of all-cause mortality.²⁵ UPFs are further linked to the consumption of suboptimal diets, leading to undesirable weight gain, obesity, and many common chronic conditions, including diabetes, chronic kidney disease, cancer, cardiovascular disease, and even depression.²⁶⁻³⁵ Inflammatory bowel diseases, lupus, allergies, and adverse perinatal outcomes have also been linked with UPF consumption.³⁶⁻³⁹

The United Nations (UN) has designated the period from 2016 to 2025 as the Decade of Action on

Nutrition, highlighting the increased production and consumption of ultra-processed foods (UPFs) as a global crisis.¹ Diets predominantly composed of these non-nutritive substances, which replace unprocessed foods, pose detrimental health effects.²⁷ Hence, it is essential for us to understand the substantial impact UPFs have on health and disease.

At the same time, a variety of minimal food processing methods exist that do not necessarily reduce the nutritive value of food⁴⁰ or may even improve access to healthy food for certain populations.⁴¹ These include flash freezing of fruits and vegetables, grinding of intact whole grains into cereals such as oat groats into rolled oats, or shelling of nuts. Additionally, the consumption of ultra-processed food products such as donuts or sugar-sweetened beverages may have deleterious health effects that exceed those of more moderately processed foods, such as homemade wheat bread made with white flour. LM practitioners should be sufficiently versed in the nuances of food processing to be able to handle questions and provide guidance to individuals.

Lifestyle Medicine Core

Competencies. Note: Seven of the 89 competencies listed below may be outside the scope of practice of non-provider health care practitioners. These competencies have been identified with an asterisk (*). The new or updated competencies have been identified with underline.

A. Introduction to Lifestyle Medicine

- (1) Discuss lifestyle medicine and its unique role in health care practice
- (2) Describe the lifestyle medicine core competencies as identified by a national consensus panel
- (3) Compare and contrast lifestyle medicine with other fields of health and medicine

- (4) Summarize the scientific evidence that shows health behaviors are associated with key health outcomes
- (5) Describe the evidence showing that lifestyle interventions effectively impact disease pathophysiology
- (6) Describe the priority of lifestyle medicine in the spectrum of treatment algorithms for chronic, lifestyle-related diseases across the lifespan
- (7) Discuss the prevalence and associated cost burden of lifestyle-related disease, such as hyperlipidemia, cardiovascular disease, prediabetes, diabetes, hypertension, obesity, and cancer
- (8) Examine the relationship between lifestyle medicine, planetary health, and sustainable living
- (9) Apply LM interventions in the context of social determinants of health (SDOH) to improve health outcomes and health equity

The Role of the Practitioner's Personal Health and Community Advocacy

- (1) Examine scientific evidence that suggests practitioners who practice healthy lifestyles are more likely to offer counseling, serve as role models, and improve patient outcomes
- (2) Develop a culture of leadership by modeling personal health behaviors
- (3) Describe strategies for incorporating personal wellness for practitioners into clinics, medical offices, or other health care settings, including wellness programs
- (4) Examine essential practitioner characteristics and practices that increase the capacity and impact of the therapeutic alliance
- (5) Integrate personal readiness assessments and lifestyle action plans into sustainable life patterns for practitioners

- (6) Explore the role of lifestyle medicine in promoting personal practitioner resiliency and reducing burnout
- (7) Advocate for lifestyle medicine directly with patients and their families, as well as policy and decision makers within the community

Nutrition Science, Assessment, and Prescription

- (1) Assess food intake patterns and nutrients of deficit and excess
- (2) Analyze food labels for the health impacts of ingredients
- (3) Discuss commonalities and key messages of global dietary guidelines.
- (4) Summarize the health impact of prominent dietary patterns, including plant predominant and non-plant predominant patterns
- (5) Appraise the evidence base related to how the level and type of food processing affects health outcomes
- (6) Describe the practice of culinary medicine and its role in sustainable healthy eating behavior
- (7) Summarize the major studies of nutrition in the prevention, treatment, and reversal of hyperlipidemia, cardiovascular disease, prediabetes, diabetes, hypertension, obesity, and cancer
- (8) Apply nutrition prescriptions based on science that shows how nutrition can address the pathophysiology of most chronic diseases, including inflammation, oxidation, glycosylation, epigenetic expression, and the microbiome*
- (9) Demonstrate the ability to write evidence-based nutrition prescriptions*
- (10) Describe indications for referral to a lifestyle medicine trained registered dietitian to translate and further personalize nutrition prescriptions

Physical Activity Science, Assessment, and Prescription

- (1) Discuss the aerobic, strength, flexibility, and balance components of physical activity
- (2) Examine the evidence and pathophysiology between physical activity components and health outcomes
- (3) Describe the benefits of physical activity in preventing or treating disease in special populations, such as healthy older adults, pregnant women, children and adolescents, persons with obesity or disability, cardiovascular disease, diabetes, cancer, disability, and stroke
- (4) Summarize the role of physical activity guidelines
- (5) Integrate key physical activity assessment tools into clinical practice
- (6) Define fitness terminology relevant to writing exercise prescriptions
- (7) Integrate evidence from relevant physical activity literature into treatment protocols for management, remission, or reversal in patients with diabetes, cancer, cardiovascular, and cerebrovascular disease*
- (8) Describe indications for referral to health fitness professionals
- (9) Develop physical activity prescriptions appropriately modified for special populations, such as healthy older adults, pregnant women, children and adolescents, persons with obesity or disability, cardiovascular disease, diabetes, cancer, disability, and stroke*

Sleep Health Science and Interventions

- (1) Describe sleep's role with health and chronic disease pathophysiology

- (2) Perform sleep assessments to identify patients with insufficient or poor-quality sleep
- (3) Summarize lifestyle-based interventions that can improve sleep health
- (4) Assess the risk for common sleep disturbances, such as obstructive sleep apnea, chronic insomnia, and restless legs syndrome, and refer to sleep specialists when applicable
- (5) Describe the indications for referral to a sleep specialist or for a sleep study to assess for sleep apnea
- (6) Describe indications for referral to a program or specialist in cognitive behavior therapy for insomnia

Treating Tobacco Use Disorder and Managing Other Toxic Exposures.

(Including Vaping, Alcohol Use, and Other Illicit Substances)

- (1) Describe the health effects of tobacco, alcohol, and other frequently used substances and the benefits of cessation
- (2) Apply patient screening tools for substance use
- (3) Create patient-centered substance use treatment plans using practice guidelines and behavioral interventions*
- (4) Summarize the diagnostic criteria for common substance use disorders
- (5) Integrate behavior therapy with pharmacotherapy for tobacco and other substance use disorder plans, and refer to a substance use disorder specialist when indicated*
- (6) Apply the United States Preventive Services Task Force guidelines for patients with tobacco use disorder

Key Clinical Processes in Lifestyle Medicine

- (1) Integrate lifestyle vital signs into components of the patient history and physical exam

- (2) Analyze and implement evidence-based clinical practice guidelines relevant to lifestyle medicine for prevention, treatment, and reversal of chronic diseases*
- (3) Describe the treatment of disease with the lifestyle medicine pillars as compared with medication
- (4) Demonstrate how to screen, diagnose, treat, and monitor a lifestyle-related disease and provide lifestyle medicine–focused anticipatory guidance*
- (5) Discuss strategies for a clinical practice to access and implement use of local, national, and global resources
- (6) Describe the key strategies for leveraging inter-professional teams to enhance health behavior change interventions
- (7) Examine how group visits and telehealth can optimize lifestyle medicine treatment encounters
- (8) Create and utilize data from office systems, such as electronic health records with lifestyle medicine guidance, in clinical decisions and care, including tracking screening frequency, test results, referrals, and recommended follow-up
- (9) Analyze the evidence for collaborative and chronic care models on improved lifestyle outcomes
- (10) Discuss successful primary care and office-based models for lifestyle modification
- (11) Design a quality improvement project for lifestyle medicine clinical practice, using tools, such as Plan-Do-Study-Act (PDSA) cycles
- (12) Explain principles of evidence-based medicine and their application to lifestyle medicine
- (13) Describe methods of assessing effectiveness of interventions, such as patient activation

measures and the therapeutic alliance measures

Fundamentals of Health Behavior Change

- (1) Summarize health behavior change theories, such as the health belief model, the social learning theory, and the transtheoretical model (TTM), and their application to lifestyle medicine practice
- (2) Demonstrate key elements of conducting a patient assessment within the TTM and collaborate to develop stage-matched responses
- (3) Apply the process of building effective and therapeutic alliances with patients that foster their personal growth
- (4) Explain how to collaborate with your patients to promote health behavior changes
- (5) Apply motivational interviewing, cognitive behavioral, health coaching, and positive psychology techniques
- (6) Summarize the evidence to support the use of behavior change techniques in clinical practice
- (7) Use the skills of open inquiry, reflections, and empathy to develop and maintain a therapeutic alliance
- (8) Describe the impact of positive emotions on the success of health behavior change
- (9) Develop patient-centered, written action plans based on the appropriate stage of change of the TTM
- (10) Summarize the process of follow-up for ongoing lifestyle change progress, including building patient self-efficacy and relapse prevention
- (11) Describe the factors that support sustained behavior change
- (12) Explain the role of family and other support to initiate and maintain health behavior change

- (13) Manage disruptions to the therapeutic alliance
- (14) Identify patient resources for sustainable behavior change in relation to the pillars of lifestyle medicine

Emotional and Mental Health Assessment and Interventions

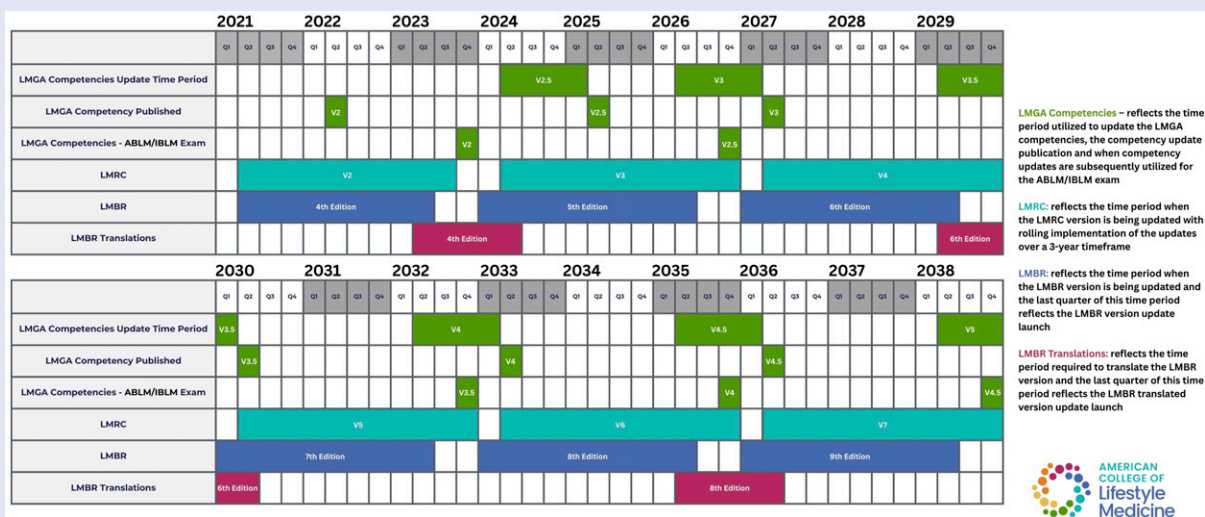
- (1) Apply screening tools for stress, depression, and anxiety in clinical practice
- (2) Explain the relationship and pathophysiology between emotional and physical health
- (3) Summarize the nature of stress, the role of stressors, such as adverse child experiences, and identify manageable elements of pathogenic stress reactions
- (4) Describe and utilize evidence-based and patient-centered mental and emotional health, including self-management and resilience-building techniques
- (5) Analyze the clinical relevance and evidence base for mindfulness-based stress reduction (MBSR) and related stress management strategies
- (6) Manage treatment plans for lifestyle-related mental health diseases, such as depression and anxiety*
- (7) Describe indications for referral to mental health professionals (versus when clinically indicated)
- (8) Apply mindfulness skills to enable presence, clarity, and curiosity in the clinical encounter

The Role of Connectedness and Positive Psychology

- (1) Apply positive psychology in health behavior change counseling
- (2) Describe how positive psychology strategies support achieving and sustaining healthy behaviors
- (3) Compare and contrast eudaimonia and hedonia, and

Figure 1.

Lifestyle medicine competency update schedule.



- explain their effect on physical health, including longevity
- (4) Describe how social connectedness and social networks effect emotional well-being, physical health, and longevity
 - (5) Summarize the deleterious and positive effects social media has on emotional well-being and flourishing
 - (6) Explain the relationship among the lifestyle pillars, positive emotions, and flourishing
 - (7) Describe positive psychology activities that can boost emotional well-being and flourishing

In addition to adding these changes or new competencies, the update schedule presented below was determined through consensus to be a feasible and workable schedule for ongoing updates.

LM Competency Update Schedule

As the LM Competencies developed over time, the need to sustain the global nature of LM emerged with

every growing step. To meet this need, the LM Competencies have undergone several revisions as previously discussed. The LMGA SAC was commissioned to create an ongoing system for maintenance and implementation of updates for these competencies. The significant factors that influenced the schedule include the following components: (1) global demand for updates to synchronize with the latest version of the Lifestyle Medicine Board Review Course (LMBR) along with the various translations needed; (2) global demand for the updates to synchronize with the ABLM and IBLM certification exam schedule; (3) global continuing medical education cycles; (4) impact of updates on the Lifestyle Medicine Residency Curriculum (LMRC) offered in graduate medical education throughout North American; and (5) impact of the updates to influence the IBLM equivalency pathway. [Figure 1](#) presents a detailed outline of the update schedule.

Application

The LM Competency schedule update will include a major update

every 6 years starting in 2027 (subsequently in 2033 and 2039) and minor updates every 6 years staggered between the major updates starting in 2030 (subsequently 2036 and 2042) to shape practice knowledge and skills and inform curricular development and revisions of the LMBR and LMRC. However, the curricula developed and revisions will not be fully implemented for approximately 2-3 years after each major or minor LM Competency update has been completed due to the workload and time required for such curricular revisions. Once each new version of the LMBR and LMRC is fully developed and revised with the most recent LM Competencies, it will take another year before those updates are realized for the English ABLM certification exam in North America. In addition, once the LMBR is launched in English, it will take yet another year before it is translated for the IBLM certification exam in countries where this is necessary. Furthermore, due to the workload and cost of the LMBR translations, the LMBR will only be translated when major LM Competency updates occur every 6 years which operationally means every

even LMBR Edition (i.e., fourth edition, sixth edition and so on).

Conclusion

This paper presents a 2025 update to the LM Core Competencies, which inform and shape the knowledge and skills necessary to practice LM globally. As the field continues to emerge, creating a scalable and sustainable infrastructure for updating and maintaining the LM Competencies is critical. With the LMGA and its Scientific Advisory Committee overseeing this new process, the LM field will continue to respond to global priorities as they arise.

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