2025 KACO Posts

January

Healthy Active Living Behaviors #2: Activity

The Clinical Report on Healthy Active Living stresses individual choices and nowhere is the importance of individual choice and appropriateness more evident than in promotion of physical activity. Preference for aerobic vs resistance, individual vs team, competitive vs non-competitive, personal vs social, indoor vs outdoor as well as physical limitations and financial or time constraints makes selecting activities very personal. As with nutrition, the guidelines we give can help families organize around the developmental stage.

Infancy: Encourage tummy time and limit time in confining equipment like seats and strollers.

Toddlerhood: Promote active play and development of fundamental movement skills.

Preschool: Encourage outside time and at least 15 minutes of activity per day.

School Age: Encourage free play and organized sports if interested, aim for 60 minutes of moderate to vigorous activity per day including muscle and bone strengthening activities three times per week.

Adolescence: As above, shoot for 60 minutes of activity per day with muscle strengthening three times per week, encourage movement in activities of daily living, support continued participation in athletics and enjoyable physical activities.

FUN RESOURCE TO HELP YOU PRESCRIBE EXERCISE: Exercise is Medicine website

February

Healthy Active Living Behaviors #3: Sleep

The understanding of the importance of sleep in health promotion has advanced remarkably over the past thirty years. Appetite regulation, cell repair, mental health, emotional well-being, longevity, metabolic health, and other functions are influenced by sleep. And getting only six hours a night is not enough, even for us busy pediatricians. Below is a summary of advice to share with your patients based on developmental stage.

Infancy: Establish good routines and sleep initiation, 14-17 hours for young infants, 12-16 for older infants

Toddlerhood: 11-14 hours per day, promote good sleep hygiene, promote bath, brush, book, bed (4B's), keep tv out of bedroom

Preschool: 10-13 hours per day, avoid screen time before bed, promote 4B's

School Age: 9-12 hours per day, same as above with screens and 4B's, no media in bedroom

Adolescence: 8-10 hours per day, avoid media as above

Looking for a simple screening tool for sleep disorders? Click here.

March

Healthy Active Living Behaviors #4: Media Use

Over the past several years, the AAP has gotten much more sophisticated with regard to media use. While 5-2-1-0 is still useful to start the discussion with regard to healthy active living, we can now get much more individualized and specific. Check out this very helpful AAP Family Media Plan and keep the following guidelines in mind for your families.

Infancy: Avoid media except for interactive video chatting

Toddlerhood: chose only high-quality programming viewed together up to 18 months; 1 hour or less for ages 2-5 years; avoid screen "baby-sitting"

Preschool: Limit as above keep tv out of bedroom and avoid within 1 hour of bedtime

School Age and Adolescence: Keep Individualized Family Media Plan and continue to avoid media in bedroom and within 1 hour of bedtime

April

Healthy Active Living Behaviors #5: Social-Emotional Wellness

Like many health indicators, the pandemic did mental health in youth no favors. Healthy active living depends on solid social-emotion and mental health wellness. No one needs to be reminded that depression, anxiety and eating disorders are on the rise. We must be diligent in screening, identification, and treatment. What follows are some developmental stage-based recommendations from the Healthy Active Living Clinical Report.

Infancy: Promote healthy interactions and bonding, promote good sleep

Toddlerhood: Promote positive parenting, start good nutrition, activity, and sleep habits; link to behavior and parenting supports as needed

Preschool: Develop emotional literacy and managing feelings, link to behavior supports as needed, continue to foster healthy nutrition, activity, and sleep habits

School Age: Continue to develop management of emotions strategies, foster good nutrition, sleep, activity and media use habits, screen for anxiety in children over 8 years, link to supports

Adolescence: Screen for depression and suicide risk over age 12 years, continue to develop healthy habits and link to supports as needed

May

Healthy Active Living: Your Role in Promotion

It is easy to think we do not have much ability to influence our patients' habits. Think again. Despite the onslaught of poorly informed politicians and certain crackpot social media influencers, patients and families continue to cite pediatricians as one of the most trusted sources of information for their families. The Healthy Active Living Clinical Report lists three

concrete actions you can take to increase the likelihood that your families will benefit from your expertise.

1) Use respectful, non-stigmatizing language when addressing a child's weight or behaviors. The Rudd Center at the University of Connecticut has great resources to reduce weight bias and stigma. In addition, the AAP Policy on Weight Bias is helpful.
2) Learn and practice communication strategies like motivational interviewing to promote behavior change.
3) Be a role model. What we do and say does make a difference! No one expects you to run a marathon, but patients do notice when we are trying. It's all in the effort!

June

Healthy Active Living: Policy in Action

The final call in the AAP Clinical Report "The Role of the Pediatrician in the Promotion of Healthy, Active Living (HAL)" is for pediatricians to change the world! Pediatricians have a vital role in creating an environment where services and support wrap around our patients promoting healthy active living.

In our communities, the call is for us to know, support, and refer to initiatives that help our patients. These communities' resources come in many different shapes and sizes. SNAP and WIC, the Y, Boys and Girls Clubs, Parks and Recreation Departments, churches, and many others can be valuable partners. Pediatricians provide referrals and expertise that make the difference between success and failure for these programs.

In the public sphere, advocating to address social determinants of health, eradicating racism, increasing activity, and reducing access to sugary drinks are all steps that can promote healthy active living. Again, pediatricians can provide the unbiased data to help policy makers.

Prevention is not as readily paid for by insurers. As with other aspects of preventive medicine, advocacy for team-based care to promote healthy active living is needed.

You can review the HAL Clinical Report in full here.

July

Trying to Make Sense of MAHA

Part1: Nutrition Recommendations

In the next few months of the KACO newsletter, we will be looking at what to make of Robert F. Kennedy Jr.'s "Make America Healthy Again" agenda and what it might mean for us as Kentucky's pediatricians. First up, nutrition. We will also delve into SNAP, GLP-1 coverage, and Medicaid issues as we move along.

The MAHA movement has been outspoken on several topics that have been at the forefront of pediatric nutrition for many years. Michelle Obama's "Let's Move", in particular, addressed many of the same concerns about diet quality, food colorings, added sugar, chronic disease, and obesogenic public policy. Interestingly, the cries of "Nanny State!" by many politicians have been remarkably absent with MAHA coming from a different administration. So, maybe that's a

good thing. While the change of heart is likely a manifestation of political loyalty, perhaps being forced to be on a different side of certain issues will open minds to ways we can make healthy choices easier.

The following article at Politico is an interview with Sam Kass, White House chef during the Obama years, and provides some good insight on the connections to and differences with the previous campaign. You can access that article HERE.

August

Trying to Make Sense of MAHA

Part 2: Supplemental Nutrition Assistance (SNAP)

The One Big Beautiful Bill (OBB) turned out to be very much the kind of bill that the AAP has been concerned about for years. Frequently, cuts to SNAP were positioned as a response to a ballooning fiscal deficit. As we know, addressing the deficit doesn't really seem to be the goal of OBB as much as trying to enact the usual 'trickle-down' economic stimulus of tax cuts. But in trying to finance those tax cuts, congress again saw SNAP as a way to cut spending.

There are several ways that SNAP cuts can affect our patients. First, state programs, because they will be footing more of the bill, will now be given more leeway in administering the program and saying what foods will and will not qualify. In theory, this isn't necessarily bad. We can all probably agree that sugary drinks should not be covered. But there are plenty of grey zones. What about cereal? What about juice? What about processed meats? Because of shifting the cost to states, Kentucky stands to be one of the hardest hit by the reduction on federal dollars.

What looks like a sad loss will be the end of funding for SNAP benefits used at Farmer's Markets. This has been a great way to get fresh fruits and vegetables to more people. It's end in the OBB is confusing, to say the least.

Kentucky is potentially going to experience worsening grocery availability. SNAP funds are never saved and are vital to small businesses in many rural Kentucky communities. Many analyses show that not only will grocery stores close, but so will other businesses who will then need to compete for remaining dollars circulating in the community.

Work verification requirements pose another worry. If history is a guide, work verification will create a lot of bureaucracy and will result in many people losing benefits because of that red tape. Arkansas remains a cautionary tale on this approach. Kentucky also had a rather disastrous attempt at this during the Bevin administration. Well over 95% of current SNAP recipients already work, but it is estimated that many will lose benefits simply due to errors, communication challenges, and inadvertently missed deadlines.

Kentucky Voices for Health has a wonderful section on SNAP and the OBB. You can reach that HERE.

September

No KACO post for this month.

October

(*by Wayne Stark, Jr., MD, FAAP*)

Many pediatricians may still be unaware of the AAP's Clinical Report, "The Role of the Pediatrician in the Promotion of Healthy, Active Living" (HAL) which was released March of this year.

Even fewer are aware of how well this report aligns with the American College of Lifestyle Medicine's (ACLM) goals.

The AAP, via the HAL Clinical Report, provides guidance to "help pediatricians address the nutritional, physical activity, sleep, media and screen use, and social-emotional factors that affect child and adolescent health and wellness." Similarly, Lifestyle Medicine is "an evidence-based medical specialty that uses therapeutic lifestyle interventions to treat, reverse, and prevent chronic conditions." The ACLM focuses on the "six pillars," defined as optimal nutrition, physical activity, sleep, stress management, avoidance of risky substances, and social connection.

They both reflect a shift in focus from a sick care model to a well care model, in which we advocate for and encourage healthy behaviors with the ultimate goals of prevention, treatment and reversal.

Therapeutic lifestyle interventions, from lifestyle prescriptions to intensive lifestyle medicine programs, are used to implement and sustain healthy lifestyles choices.

Intensive Therapeutic Lifestyle Change treatment programs use evidence-based strategies such as Shared Medical Appointments to induce sustainable behavioral change. These programs generally occur over a year, with the intensive portion occurring 1-3x a week during an 8–12-week initiation phase and less frequently for the remainder of the program. Such programs generally exceed the 26 contact hours suggested by the USPSTF* and, in adults, the ACLM has a growing body of evidence supporting their success in inducing and sustaining behavioral change.

In a recent Medscape article, current ACLM President Padmaja Patel, MD advocates for documenting and tracking lifestyle factors, like how we document vital signs such as blood pressure. Similarly, the AAP's clinical report references *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*,4th ed encourages us to "assess a child's nutrition, physical activity, sleep, screen use, and social-emotional wellness at each well-child visit" and to use this baseline information to assess opportunities for intervention.

The ACLM expects leaders to practice healthy personal behaviors, while the AAP's clinical report encourages parents and caregivers to "role model healthy patterns" and admonishes us providers to serve as role models.

The biggest difference between the ACLM and AAP is a unique focus on pediatric patients. While ACLM is for everyone, most evidence for their interventions is based in adult patients. Fortunately, as anyone knows who has read Perri Klass' *A Good Time to Be Born*(re-released as *The Best Medicine*), we Pediatrician's shine brightest when we focus on prevention.

*It is worth considering the USPSTF contact hour recommendations when we see discouraging results from research studies attempting behavioral change in the pediatric population. If the experimental intervention falls short of USPSTF contact hour recommendations, how should we interpret those results? If an intervention fails in a trial, but was performed below recommendations, did the intervention truly fail? Many successful interventions will fail if underdosed.

In this article she references the ACLM's Diet Screener and

https://www.medscape.com/viewarticle/its-time-treat-lifestyle-vital-sign-ehrs-2025a1000nza

November

Interested in Board Certification in Lifestyle Medicine? While credentialing is work, it is readily achievable. If you're seriously considering Lifestyle Medicine Certification, one to two years is a very reasonably time frame to achieve it. Feel free to use the following link for further information:

https://lifestylemedicine.org/a-step-by-step-guide-to-lifestyle-medicine-certification/

First things first. Become a member of the American College of Lifestyle Medicine. It costs $150-250, and it makes you eligible for reduced prices for many of the prerequisites.

What is it? And why certify?

I'll quote the ACLM here: "Lifestyle medicine is a medical specialty that uses therapeutic lifestyle interventions as a primary modality to treat chronic conditions including, but not limited to, cardiovascular diseases, type 2 diabetes, and obesity. Lifestyle medicine certified clinicians are trained to apply evidence-based, whole-person, prescriptive lifestyle change to treat and, when used intensively, often reverse such conditions. Applying the six pillars of lifestyle medicine—a whole-food, plant-predominant eating pattern, physical activity, restorative sleep, stress management, positive social connections, and avoidance of risky substances—also provides effective prevention for these conditions."

Per the American College of Lifestyle Medicine, certification "signifies specialized knowledge in the practice of lifestyle medicine and distinguishes a physician as having achieved competency" and "signifies mastery and competency in using lifestyle as a way to treat, reverse, and prevent chronic disease."

As pediatricians, we understand the value of preparing children for long, happy, healthy lives. We are generally under-represented in the LM community; many of us are working to change that.

Two pathways, but really just one

There are generally two different pathways to certification: an educational pathway and an experiential pathway. The educational pathway requires you to be in medical training in a program with a Lifestyle Medicine Residency Curriculum (LMRC). Unless you are a member of the Baptist Health Deaconess | Family Medicine Residency, which is the only LMRC in

Kentucky, then this won't be for you. (As a shameless plug, I'd love to see us integrate more LMRC's into our existing educational programs.)***

This leaves us with the experiential pathway. Let's talk about that.

Are you the right type of provider?

To certify as a Lifestyle Medicine Physician, you must have US primary board certification for at least 2 years via ABM or AOA; Canadians must be licensed to practice as a physician.

If you're not a physician, you can still certify as a provider. To certify as a Lifestyle Medicine Professional you must hold a masters' or doctorate degree in a health discipline.

If you meet those requirements, you may complete the prerequisites and then sit for examination.

What are the prerequisites?

All CME prerequisites must be completed within 36 months of the exam date.

Online CME

You will need to complete 30 hours of online CME from an approved course. There are many ways to do this, but the best way to get the appropriate CME while preparing for the American Board of Lifestyle Medicine examination is to take the Foundations of Lifestyle Medicine Board Review course.*

Live CME

You will also need to complete 20 hours of live CME from an approved event. The ACLM's annual conference is my preferred way to do this, but there are many other options. The full list of eligible options is available at the following website: ablm.org/eligibility-prerequisites/. The annual conference is typically in the fall, often October to November. For 2026, the conference will be held November 8-11, 2026, Rosen Shingle Creek, Orlando, FL. At the time of this writing, virtual conference attendance counts towards the Live CME.

Case study

Additionally, physicians are required to complete a case study outlining their personal experience with a lifestyle medicine case. This is a fairly generous requirement; the case study could be a patient, family, friend or even yourself.

What and when is the exam?

Proctored by Prometric, it has 150 multiple choice questions for physicians, 120 for professionals, and you'll have 4 hours to complete it. Exam week is usually last week of November, first week of December. The current window for 2026 is between November 21st and December 6th. Registration is currently open.**

A heads-up for us pediatricians. There isn't currently a pediatric lifestyle medicine subspecialty. You will be answering questions about the management of adult patients. For most of us that have been out of training and working almost exclusively with pediatric patients, this may seem a bit intimidating. Don't sweat it, you've got this.

What are the deadlines?

It is reasonable to Board Certify in Lifestyle Medicine in one year, if motivated. Two years would be plenty of time.

Registration for the exam ends late September. However, you don't need to have all of your prerequisites ready at the time of registration; they are due late October, with one very important exception: ACLM conference live in-person CME are exempt from this deadline. So, if someone is motivated and wants to sit for the exam next year, they could reasonably count the next annual conference(November 8-11th 2026) towards their live CME so that they're ready for the exam November 22nd-December 7th. Alternatively, they could attend the annual conference virtually, as this will still count towards your live CME. You will want to upload your CME from the conference as soon as you can after the event. You may still sit for the exam without having all prerequisites uploaded. But you will not receive your exam results until everything is uploaded and reviewed. If for some reason, this doesn't work out for you, then you'd be more than ready to sit for the exam next year.

MOC

And what about MOC? Well, you can commit to take the exam every 10 years, or you can opt for the alternative MOC, like I have. You will have several articles on LM topics to review every year and will be required to complete a quiz with a passing grade for each one. You will also need to complete 30 hours of CME every 5 years.

TL;DR
How do I credential in lifestyle medicine?
-30 hours online CME (Foundations of Lifestyle Medicine Board Review Course is simplest and best)
-20 hours live CME (the ACLM national conference is best)
-Case Study
Then take the exam!

I hope this helps! Obviously, the ACLM and ABLM have plenty of additional information on their websites to address any further questions.

*The Foundations of Lifestyle Medicine Board Review Course meets the 30-hour CME requirement and helps to prepare for the exam. As of this writing, it's about 899.00.

As for how it is structured, there are 10 sections for the Board Review eBook, 10 hours of online review lectures, 10 section quizzes that correspond to the 10 eBook sections and review lectures, for a total of about 180 questions.

There are three components: a 354-page Board Review, 10 hours of online review lectures and eBook, 10 corresponding quizzes(approximately 180 questions).

**Prices may vary but expect to pay around 1500 to take the certification exam.

***More information on starting LMRC's can be found here:
https://lifestylemedicine.org/academic-integration/residency-curriculum/

Do not be intimidated by their optimism and ambition. There is a lot that they'd like to do within a residency program, but it is generally understood that you have to start somewhere and

build upon this. What they show on this website is their gold standard, but most programs offer far less than this. They offer a sample curriculum as well as faculty support and scholarships to get things started and help programs progress.

December

A recent Swedish study has new, encouraging results:

In Sweden, pediatric obesity treatment is offered customarily and free of charge. As a result, Swedish children generally receive treatment at an earlier age and lower degree of obesity. Patients who undergo obesity treatment are prospectively registered in BORIS, The Swedish Childhood Obesity Treatment Register.

A 2020 study of 21,499 children enrolled from 2004-2017 showed that "the effect of childhood obesity treatment on standard anthropometric measures has not improved over the investigated years," with BMI SDS being the anthropometric measure. It is worth noting that age and BMI SDS enrollment decreased throughout the years.

But BMI isn't everything. And what about the children who responded well to the treatment? Did it matter for them?

A newer study suggests so.

In this study, 6,713 children were identified from the BORIS database who had received at least one year of obesity treatment from 1996 to 2019 were identified.

Participants received at least one year(average 3) of obesity treatment from 6-17 years of age(average age 12) and treatment response was determined via BMI SDS and defined as poor(increase BMI 0.25 or more), intermediate(decrease 0.24 to increase 0.24 units), good(decrease of 0.25 or greater) or obesity remission.

6,713 children and their general population comparators were followed in this dynamic prospective cohort.

They observed that "beneficial pediatric obesity treatment response yielded enduring health benefits, markedly lowering future morbidity and mortality risks in young adulthood."

Obesity remission or a good response in obesity treatment, when compared with poor response, was associated with reduced risk of mortality, lower risk of TD2, dyslipidemia, and bariatric surgery. Obesity remission also showed a reduced risk of hypertension.

So, what is the take home message? We may not always see the change we wish to see, but for the patients that the intervention helped, the effects may be lifechanging.

Putri RR, Danielsson P, Ekström N, et al. Effect of Pediatric Obesity Treatment on Long-Term Health. JAMA Pediatr. 2025;179(3):302–309. doi:10.1001/jamapediatrics.2024.5552

Hagman E, Danielsson P, Lindberg L, Marcus C; BORIS Steering Committee. Paediatric obesity treatment during 14 years in Sweden: Lessons from the Swedish Childhood Obesity Treatment Register-BORIS. Pediatr Obes. 2020 Jul;15(7):e12626. doi: 10.1111/ijpo.12626. Epub 2020 Feb 19. PMID: 32074662.