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Lifestyle Interventions for Treatment and Remission of Type 2 Diabetes and Prediabetes in Adults: A Clinical Practice Guideline from the American College of Lifestyle Medicine

Wednesday, January 21, 2026

Presented by Mahima Gulati, MD, FACE, FACLM

Moderator:
Lisa Diewald, MS, RDN, LDN
Associate Director
MacDonald Center for Nutrition Education and Research

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Continuing Professional Development Details

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- The CPE activity application for this activity is pending CDR review and approval for 1 CPEU.

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    - To receive CE credit, you must attend the entire program.

The Q&A Box is Open!

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- Questions are welcome!
- Please send through the Q&A Box during the presentation.
- Q&A session will follow the program.

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Clinical Practice Guideline

Lifestyle Interventions for Treatment and Remission of Type 2 Diabetes and Prediabetes in Adults: A Clinical Practice Guideline From the American College of Lifestyle Medicine

This guideline has been endorsed by the American Association of Clinical Endocrinology, American Academy of Physician Associates, American Association of Nurse Practitioners, American College of Clinical Pharmacology, Obesity Medicine Association, American Academy of Sleep Medicine, Association of Diabetes Care & Education Specialists, and National Board of Health and Wellness Coaches. It has been designated with an "Affirmation of Value" from the American Academy of Family Physicians and is supported by the Academy of Nutrition and Dietetics.

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AMERICAN COLLEGE OF Lifestyle Medicine

LIFESTYLE INTERVENTIONS FOR TREATMENT AND REMISSION OF TYPE 2 DIABETES AND PREDIABETES IN ADULTS: A CLINICAL PRACTICE GUIDELINE FROM THE AMERICAN COLLEGE OF LIFESTYLE MEDICINE

MAHIMA GULATI, MD, FACLM, FACE, DIPABLM, MSCI, ECNU

DISCLOSURES

- NONE

UCONN HEALTH

ENDOCRINOLOGY, DIABETES AND METABOLISM

OBJECTIVES

- Understand the purpose and structure of the new ACLM Diabetes and Prediabetes Clinical Practice Guideline (CPG)
- Explore *key action statements*, and the evidence behind them.
- Learn how to apply the CPG in clinical settings

WHAT IS A CLINICAL PRACTICE GUIDELINE?

- They are systematically developed statements intended to assist clinicians and patients in making decisions about appropriate health care for specific clinical circumstances, based on a rigorous review of available evidence, predominantly, focusing on high-quality evidence from systematic reviews, metanalyses, and randomized controlled trials..
- They are meant to serve as a decision-making support, to help clinicians and healthcare professionals, as well as patients, determine optimal approaches, and to avoid/ reduce ineffective or harmful care options.
- By providing a standardized framework, they aim to reduce redundant variations in care, and help empower patients and healthcare professionals, plus provide a broader policy framework for payers and systems

PURPOSE AND VISION OF THIS CPG

- Provide actionable guidance to any clinician or healthcare professional in a community or outpatient healthcare setting involved in managing **non-pregnant adults** with T2D, prediabetes or a history of gestational diabetes mellitus (GDM).
- Promote **standardized, lifestyle-focused** clinical care
- Align with the **ACLM vision of root cause resolution**

PARADIGM OF "GUIDELINE-DIRECTED LIFESTYLE THERAPY"

AN INTERDISCIPLINARY TEAM OF AUTHORS

Guideline Leadership: Richard M. Rosenfeld (Methodologist & Chair), Meagan L. Grega (Family Medicine & Assistant Chair), Mahima Gulati (Endocrinology & Assistant Chair)
ACLM Staff: Micaela C. Karlsen, Kara L. Staffier

Guideline Development Group:
Abd Moain Abu Dabrh (Health & Wellness Coaching)
R. Nisha Aurora (Sleep Medicine)
Jonathan P. Bonnet (Family Medicine)
Lori Donnell (Consumer Advocate)
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Jonathan M. Weber (Advanced Practice Provider)

ENDORSING/SUPPORTING ORGANIZATIONS

- This guideline has been endorsed by the American Association of Clinical Endocrinology, American Academy of Physician Associates, American Association of Nurse Practitioners, American College of Clinical Pharmacology, Obesity Medicine Association, American Academy of Sleep Medicine, Association of Diabetes Care & Education Specialists, and National Board of Health and Wellness Coaches.
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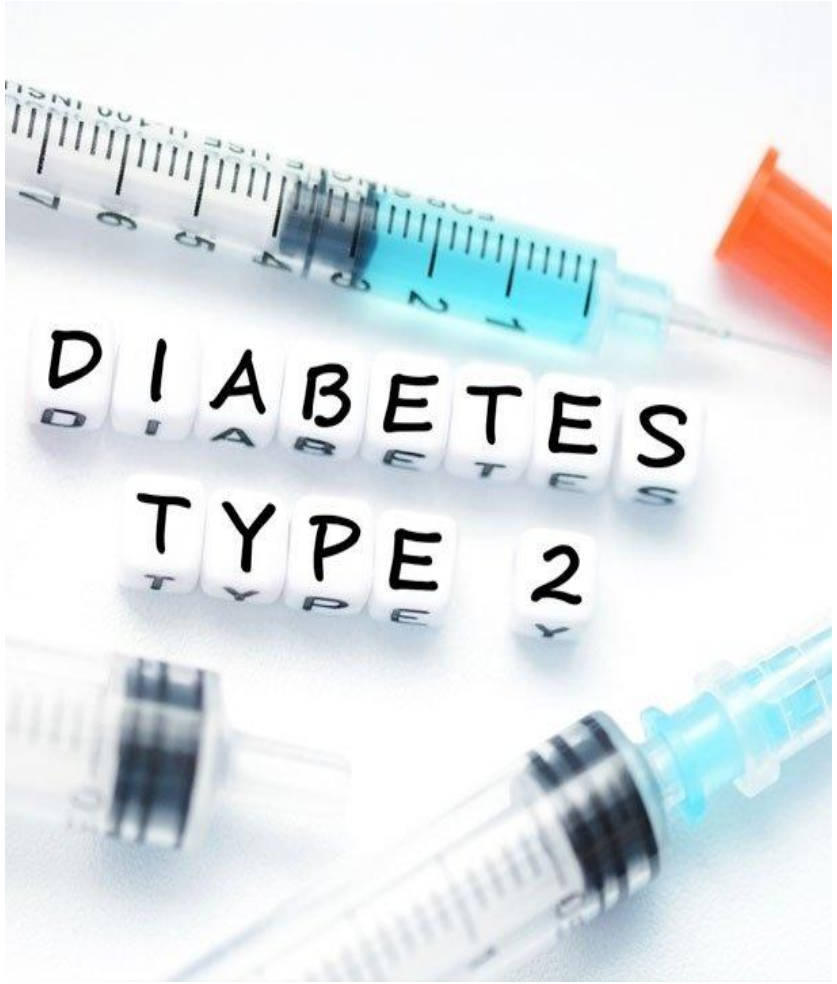
- It is supported by the Academy of Nutrition and Dietetics.

THE GLOBAL BURDEN OF TYPE 2 DIABETES



- Diabetes termed an *epidemic and defining disease of the 21st century* because of rising prevalence, and enormous depth and breadth of health impact
- Globally, about 1.3 billion people expected to have diabetes by 2050, with projected cost of type 2 diabetes over $1 trillion
- About 50% of US population has diabetes (13.2%) or **prediabetes (36.5%)**, making up 25% of total health care dollars
- 80% of all type 2 diabetes is preventable with lifestyle therapy.

Wang H et al, Partners in diabetes epidemic: a global perspective, World J Diabetes 14:1463-7. Editorial, Diabetes a defining disease of the 21st century, Lancet 2023; 401:2087. CDC, Nat'l Diabetes Prevention Coverage Toolkit, Cost & Value, 2024; https://coveragetoolkit.org/cost-value-elements/

UNIQUE VALUE OF ACLM'S GUIDELINE ON T2D

- **A 122-page document focused only and exclusively on lifestyle therapy, and on all *six* pillars of lifestyle medicine**
- **Distinguishes between and provides systematic framework for treatment vs *remission* of type 2 diabetes mellitus**
- Built on **multidisciplinary consensus from diverse stakeholders, enabling depth and breadth to therapeutic nuance**
- Provides **structured treatment algorithms, 30 figures and 30 tables, to help guide busy practicing HCPs in their day-to-day practice and pragmatic decision making**

PURPOSE AND INTENT OF CPG

- The CPG is not a comprehensive summary of how to manage prediabetes or T2D, nor is it intended to *replace* other guidelines.
- Instead, we focus explicitly on lifestyle changes while excluding other information (such as diagnosis, prevention, medical treatment, dealing with complications) that is extensively dealt with by other guidelines.
- The value of this CPG lies not so much in its novelty, but in its granularity.
- Also, to address misinformation and disinformation

Classifying Recommendations for CPGs: Oxford Center for Evidence-Based Medicine (OCEBM) Levels

Table 12. Aggregate Grades of Evidence by Question Type[a]

Grade	OCEBM Level	Treatment	Harm	Diagnosis	Prognosis
A	1	Systematic review[b] of randomized trials	Systematic review[b] of randomized trials, nested case-control studies, or observational studies with dramatic effect[b]	Systematic review[b] of cross-sectional studies with consistently applied reference standard and blinding	Systematic review[b] of inception cohort studies[c]
B	2	Randomized trials or observational studies with dramatic effects or highly consistent evidence	Randomized trials, or observational studies with dramatic effects or highly consistent evidence	Cross-sectional studies with consistently applied reference standard and blinding	Inception cohort studies[c]
C	3-4	Nonrandomized or historically controlled studies, including case-control and observational studies	Nonrandomized controlled cohort or follow-up study (postmarketing surveillance) with sufficient numbers to rule out a common harm; case-series, case-control, or historically controlled studies	Nonconsecutive studies, case-control studies, or studies with poor, nonindependent, or inconsistently applied reference standards	Cohort study, control arm of a randomized trial, case series, or case-control studies; poor quality prognostic cohort study
D	5	Case reports, mechanism-based reasoning, or reasoning from first principles			
X	NA	Exceptional situations where validating studies cannot be performed and there is a clear preponderance of benefit over harm			

RECOMMENDATION STRENGTH IS DETERMINED BY THE AGGREGATE LEVEL OF EVIDENCE AND THE BENEFIT-HARM BALANCE

Evidence Grade	Preponderance of Benefit or Harm	Balance of Benefit and Harm
A	Strong Recommendation	Option
B	Strong Recommendation / Recommendation	Option
C	Recommendation / Option	Option
D	Option	No Recommendation
X	Strong Recommendation / Recommendation	Not Applicable

DIABETES CPG: SUPPORTING EVIDENCE

126 Systematic Reviews, 107 Randomized Trials, 8 Guidelines, 6 Umbrella Reviews, 55 Observational Studies, 14 Review/Consensus Sources

physical activity
diet/nutrition
implementation
PA: aerobic exercise
PA: resistance training
LM General
stress/mental health
Diet: diet type/pattern
PA: HIIT
TECH CGM
PA: activity breaks, walking
Diet: food type/pattern
Diet: low carb
Diet: nutrition therapy/education

LM: DPP/ILI
SUPPORT: peer/family
IM: education
DM tech
IM: phone/texting
Diet: weight loss
Diet: energy restriction
IM: virtual/web-based
Diet: high protein
sleep
LM: diet + physical activity
TECH: Apps/digital
STRESS: anxiety/depression

STRESS: mindfulness/meditation
IM: behavior/CBT
SUPPORT: community
PA: yoga
IM: peer/social support
LM: weight reduction
SLEEP: General
substance use
IM: coaching
PA: mind/body, pilates
IM: groups/SMAs
IM: DPP/ILI
SUPPORT: group
STRESS: stress reduction

IM: cooking/culinary
TECH: physical activity
STRESS: mental health
Bariatric surgery vs LM
LM: LM gen
Diet: ketogenic
IM: miscellaneous
SUBSTANCE: alcohol
PA: Balance training
SLEEP: OSA/CPAP
STRESS: mood/coping
IM: multimodality
LM: miscellaneous
SUBSTANCE: smoking
Diet: plant-based

rayyan
INTELLIGENT SYSTEMATIC REVIEW

CPG COMPONENTS

Introduction and background

14 Key Action Statements

Implementation resources

Tables, figures, references

ANATOMY OF AN ACTION STATEMENT

Includes:

Quality improvement opportunity

Strength and confidence of evidence

Value judgments

Patient preferences

Implementation insights

KAS#4: Prescribing Aerobic & Muscle Strength Physical Activity

Aerobic and Muscle Strength Physical Activity: The clinician or healthcare professional should prescribe physical activity, with an emphasis on aerobic and muscle strength training, by establishing SMART goals and using the FITT (frequency, intensity, time, type) framework for implementation for adults with prediabetes, type 2 diabetes, or a history of gestational diabetes mellitus.

Strong recommendation **based on randomized controlled trials and systematic reviews with a preponderance of benefit over harm.**

Evidence profile:

- **Aggregate evidence quality:** Grade A, based on 3 systematic reviews and meta-analyses, 2 RCTs, and 2 longitudinal cohort studies demonstrating the benefits of regular physical activity for individuals with dysglycemia
- **Benefits:** Improved glycemic control, cardiorespiratory fitness, sleep quality, cognitive function, mental health, health-related quality of life (HRQOL), and cardiometabolic markers; assistance with stress and weight management; fewer major adverse cardiovascular events (MACE); decreased all-cause and diabetes related mortality; less progression of sarcopenia, preserve lean muscle mass; reduced disability; improved resilience; reduced healthcare costs; enhanced bone health; increased adherence to physical activity recommendations
- **Risk, harm, cost:** Injury from improper activity; hypoglycemia; compensatory overeating; patient frustration if unable to adhere to prescription (e.g., limited access to needed facilities); overexercise; ischemic and arrhythmogenic heart disease; cost of access to equipment, facilities

Value judgments: The GDG chose to emphasize aerobic activity and muscle strength training because they align with physical activity guidelines for Americans, and are most evidence-based, but also recognize that physical activity can include other modalities

THE FIRST 3 KEY ACTION STATEMENTS IN THE GUIDELINE

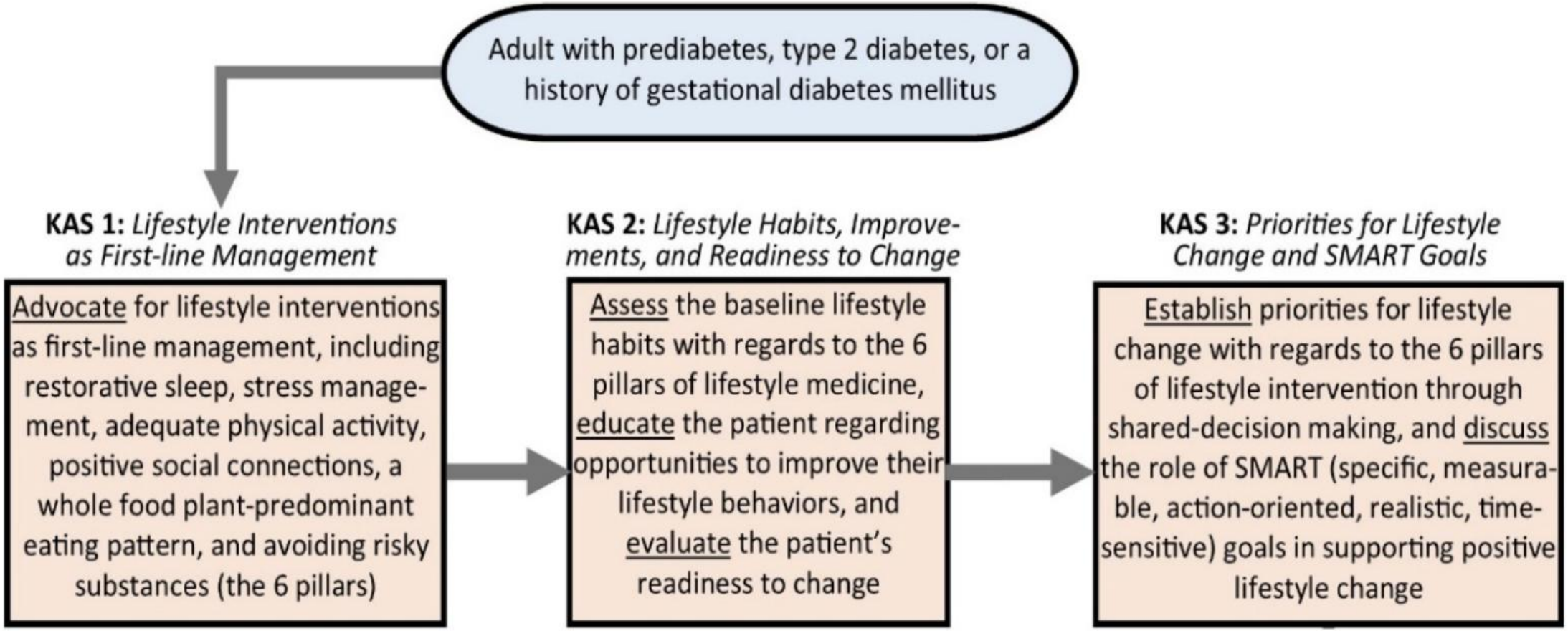


Figure 10. Ladder for coaching or counseling a patient to continue to set new goals, which are like steps on a ladder to reaching their vision and purpose in life. The sides of the ladder are their priorities and their values. The SMART goals need to connect with the person's priorities and values to be inspiring and motivating, using an iterative process that revisits the person's mission in life. The SMART goals are how the person moves upward toward their healthiest self.

Recommended Lifestyle Medicine Tool Examples by Domain

Lifestyle Medicine Domain	Brief Assessment Tool (items), best suited for clinical practice	In-Depth Assessment (items) for research or clinical practice
Global Screen	Lifestyle Medicine Assessment[21, 100] Loma Linda University Short Form[20, 101]	Loma Linda University Long Form (150+ items)[102]
Avoidance of Risky Substances	Alcohol Use Disorders Identification Test[3] (AUDIT-C),[105] NIDA Quick Screen[4, 106]	AUDIT,[105] NIDA Modified Assist[8, 106]
Nutrition	ACLM Diet Screener[27, 107] Starting the Conversation[8, 108]	Automated Self-administered 24- Hour Recall,[109] Food diaries, Food frequency questionnaires
Physical Activity	Exercise Vital Sign (EVS)[110] Physical Activity Vital Sign (PAVS)[111]	International Physical Activity Questionnaire,[7, 112] Physical Activity Scale for the Elderly[10, 113] (10+ items)
Positive Social Connection	A Brief Measure of Social Support[27, 114]	
Sleep	Single Sleep Quality Scale,[1, 115] Patient-Reported Outcomes Measurement Information System (PROMIS)[116]	Pittsburgh Sleep Quality Index[10-24, 117]
Stress Management	Perceived Stress Scale (PSS) 4 Item[4, 118] Patient Health Questionnaire (PHQ) 2 item[2, 119] Generalized Anxiety Disorder (GAD) 2 item[2, 120]	PSS,[10, 121] PHQ-9, [9, 122] GAD-7,[7, 123]

KAS#5: Reducing Sedentary Time

Reducing Sedentary Time: The clinician or healthcare professional should prescribe physical activity to reduce sedentary time, using SMART goals, for adults with prediabetes, type 2 diabetes, or a history of gestational diabetes mellitus.

Strong recommendation based on randomized controlled trials, systematic review, and observational studies with a preponderance of benefit over harm.

Evidence profile:

- **Aggregate evidence quality:** Grade B, based on systematic reviews,meta-analyses, and RCTs on the effectiveness of using physical activity to reduce sedentary time in the management of prediabetes and T2D
- **Benefits**: Promote awareness of the adverse impact of sedentary activity; educate patients about how even small levels of physical activity to interrupt sedentary time are beneficial; improve glycemic control
- **Risk, harm, cost**: None
- **Benefits-harm assessment**: Preponderance of benefit over harm

Value judgments: Potential lack of awareness by clinicians and individuals of how harmful excessive sedentary time can be for type 2 diabetes and overall health

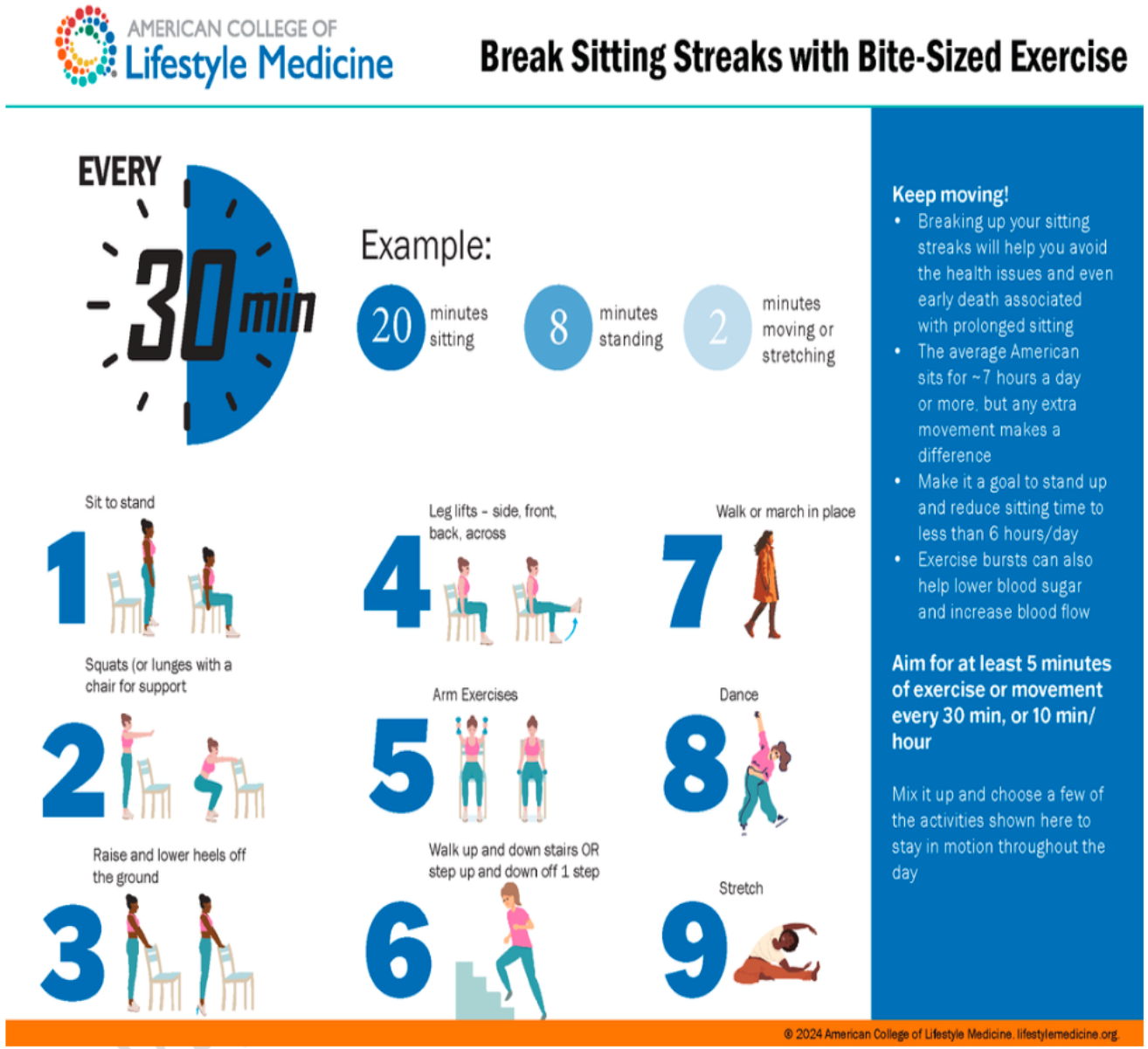


Figure 14. Breaking Sitting Streaks. Examples of how Exercise "Snacks" or "Bite-sized Exercise" regimens can be easily integrated into everyday activities by increased standing time and a few 2-to-3-minute exercise bursts throughout the day.

KAS#6: Identifying Sleep Disorders

Sleep disorders: In adults with prediabetes, type 2 diabetes, or a history of gestational diabetes mellitus, the clinician or healthcare professional should ask about sleep quality, quantity, and patterns, determine if a sleep disorder is present, and refer, as indicated, for further evaluation and management.

Sleep disorders associated with prediabetes, type 2 diabetes, and a history of gestational diabetes include, but are not limited to, obstructive sleep apnea, shift work sleep disorder, chronic insomnia, and short or long sleep duration.

Strong recommendation **based on randomized controlled trials, systematic reviews, and observational studies with a preponderance of benefit over harm.**

Evidence profile:

- **Aggregate evidence quality**: Grade B, based on RCTs and systematic reviews with meta-analyses of both randomized controlled trials and observational studies indicating an association and examining management of prediabetes and T2D for delineated sleep disorders
- **Benefits**: Prioritize additional assessment and intervention of individuals who require further evaluation to improve sleep quality, avoid complications, or sequelae, of an underlying sleep disorder that may not have been previously recognized or diagnosed; raise awareness of optimal sleep duration and patterns for better disease-specific and overall health, providing information and strategies on how to improve sleep behaviors, avoiding lifestyle behaviors that could impair sleep patterns; offer specific, individualized advice
- **Risk, harm, cost**: Time; cost of additional assessment, testing, or referral; limited access to individuals who can perform the needed additional evaluations; frustration if unable to achieve goals
- **Benefits-harm assessment**: Preponderance of benefit over harm

KAS#7: Prescribing a Nutrition Plan for Prevention of T2D

Nutrition Plan for Prevention: In adults with prediabetes, or a history of gestational diabetes mellitus, the clinician or healthcare professional, or their designee, should prescribe a nutrition plan using SMART goals that is consistent with the patient's cultural background and is framed in food-based advice regarding caloric intake, nutrient needs, and a whole-food, plant-predominant eating pattern.

Strong recommendation **based on randomized controlled trials and systematic reviews with a preponderance of benefit over harm.**

Evidence profile:

- **Aggregate evidence quality**: Grade A, based on systematic reviews, meta-analyses, and RCTs on the effectiveness of using evidence-based strategies for implementing nutrition and food-based strategies for preventing T2D
- **Benefits**: Prevent progression of prediabetes to T2D, achieve normoglycemia in people with prediabetes, prevent recurrence of GDM, prevent progression of GDM to T2D, dispel nutrition myths and misinformation
- **Risk, harm, cost**: Time; cost of food; a focus on weight loss could be problematic for someone with disordered eating behaviors, time counseling patients
- **Benefits-harm assessment**: Preponderance of benefit over harm
- **Value judgments**: There is a perception among the GDG that the importance of a history of GDM is underappreciated as an opportunity for nutritional intervention to prevent recurrence or progression. Although the GDG recognizes that prevention of T2D is the optimal goal for people at risk for T2D, not everyone may be willing to commit to the degree of intervention, and should this occur, a goal of improvement is reasonable. It is the perception of GDG that for T2D prevention, nutrition and physical activity should be a frontline approach to treatment for prediabetes and are not always communicated and offered as an option

Easy Ways to Add Fiber

Common Ultra-Processed Foods

INSTEAD OF...

Half a bagel = 1 gram of fiber

A glass of juice = 1 gram of fiber

A handful of chips = 1 gram of fiber

A cup of white rice = 0.5 gram of fiber

A pudding cup = 1 gram of fiber

Total Fiber: 4 grams

Healthy Whole Foods

EAT...

1/2 cup of oatmeal = 4 grams of fiber

1 medium orange = 3 grams of fiber

A handful of nuts = 4 grams of fiber

1/2 cup of brown rice and 1/4 cup of beans = 6 grams of fiber

1 cup blueberries = 3 grams of fiber

Total Fiber: 25 grams

KAS#8: Prescribing a Nutrition Plan for Treatment OR REMISSION

Nutrition Plan for Treatment: The clinician or healthcare professional, or their designee, should clarify with the person with type 2 diabetes if their goal is to **achieve type 2 diabetes remission or type 2 diabetes improvement** and should prescribe a nutrition plan using SMART goals that is consistent with the patient's desired outcome(s), cultural background, and is framed in food-based guidance promoting appropriate energy intake, nutrient needs, and the benefits of a whole-food, plant-predominant eating pattern.

Strong recommendation **based on randomized controlled trials and systematic reviews with a preponderance of benefit over harm.**

Evidence profile:

- **Aggregate evidence quality**: Grade A, based on 31 systematic reviews or meta-analyses and on 11 RCTs
- **Benefits**: Determine the type and intensity of nutritional intervention; avoid implementing a plan that is unlikely to be accepted by, or adhered to, by the patient; educate the patient about the potential to achieve remission in many adults with T2D; promote adherence to recommendations; educate, advise, and inform the patient; offer specific and actionable advice that is tailored to the patient's needs and preferences; raise awareness regarding the three key areas of focus: energy/calories, nutrients, and a low-fat plant-predominant eating pattern; focus on process. not outcomes, to improve adherence
- **Risk, harm, cost**: No risk for asking patients to clarify their T2D remission or improvement goals; however, the patient may be unreceptive to advice, or overwhelmed, if not managed in a sensitive, easy to understand, professional manner. Costs include food cost, risk of disordered eating, stigma, lack of access to appropriate and culturally acceptable food (e.g., problems in food deserts, food swamps, and with food apartheid)

Value judgments: Although the GDG recognizes that remission is the optimal goal for adults with T2D if physiologically feasible, not all patients may be willing to commit to this degree of intervention, and should this occur, a goal of improvement is reasonable. It is the perception of GDG that remission and diet as a frontline approach to treatment are not always communicated as options to patients with T2D

DIABETES IN REMISSION NOW ITS OWN ICD-10 BILLABLE DIAGNOSIS CODE

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2026
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Newsflash: New ICD-10 Code Recognizes Type 2 Diabetes Remissior

A major milestone for lifestyle medicine

The 2025 ICD-10 update introduces E11.A — Type 2 diabetes in remission, enabling clinicians to document remission achieved through lifestyle intervention or other therapies.

(b) ***Type 2 diabetes mellitus in remission***

Code E11.A, Type 2 diabetes mellitus without complications in remission, is assigned based on provider documentation that the diabetes mellitus is in remission. If the documentation is unclear as to whether the Type 2 diabetes mellitus has achieved remission, the provider should be queried. For example, the term "resolved" is not synonymous with remission.

AMERICAN COLLEGE OF Lifestyle Medicine

Moving Toward a Plant-Predominant Whole Food Eating Pattern

Increase whole plant foods, fruits, vegetables, whole grains, beans, legumes, nuts, seeds, and water.

Decrease sweets and snacks, fast food, fried food, refined grains, refined sugar, meat, dairy, eggs, and high sodium foods.

Ardmore Institute of Health

KAS#9: Peer/Familial Support and Social Connections

Peer/Familial Support and Social Connections: The clinician or healthcare professional should counsel adults with prediabetes, type 2 diabetes, or a history of gestational diabetes mellitus regarding the importance of cultivating positive social connections provided by peers, family members, and/or other professionals trained in lifestyle change methods to achieve SMART goals and optimize glycemic control.

Strong recommendation **based on randomized controlled trials and systematic reviews and meta-analyses with a preponderance of benefit over harm.**

Evidence profile:

- Aggregate evidence quality: : Grade A, based on 41 RCTs, 6 meta-analyses, 4 systematic reviews. and 1 umbrella review demonstrating consistently that support interventions lead to improved outcomes in prediabetes and T2D managementt
- Benefits: Improve adherence to SMART goals, promote sustainable lifestyle behaviors, enhance positive social connections
- Risk, harm, cost: None

Value judgments: There is a perception among the GDG that the importance of peer support, family support, and positive social connections may be underappreciated as a factor that influences outcomes

KAS#10: Identifying a Need for Psychological Interventions

Psychological Interventions: In adults with prediabetes, type 2 diabetes, or a history of gestational diabetes mellitus the clinician or healthcare professional should identify or refer to someone who can identify serious mental illness such as severe mood/affective disorders, anxiety disorders, or psychotic disorders. For patients experiencing stress or symptoms of depression or anxiety, prescribe mindfulness-based, cognitive behavioral therapy (CBT), or CBT-based interventions to improve diabetes clinical outcomes.

Recommendation **based on randomized controlled trials, systematic reviews, and meta-analyses with a preponderance of benefit over harm.**

Evidence profile:

- Aggregate evidence quality: Grade B, based on 10 combined systematic reviews and meta-analyses, 2 systematic reviews, and 9 RTCs, with some limitations regarding methodology, study design, and sample size-indicating the relationship between diabetes and mental health and the effectiveness of psychological interventions (e.g., mindfulness-based interventions and CBT) for the management of T2D
- Benefits: Prioritize additional assessment and intervention for individuals who require further evaluation to improve mental health; avoid complications or sequelae of an underlying mental illness that may not have been previously recognized or diagnosed, better inform the management plan for diabetes mellitus by taking into account comorbid mental illness; raise awareness of stress management strategies for better disease-specific and overall health; identify diabetes distress burden and develop strategies to reduce them; provide information and strategies on how to improve mental health; reduce anxiety; and improve coping skills
- Risk, harm, cost: Time, cost of additional assessment testing or referral, limited access to individuals who can perform the needed additional evaluations; frustration if unable to achieve goals
- Benefits-harm assessment: Preponderance of benefit over harm

Value judgments: Perception by GDG that routine assessment of mental health is not always part of managing a person with T2D, but that this assessment is important for identifying conditions that may require special assessment, referral, or management

KAS#11: Tobacco, Alcohol, and Recreational Drugs

Tobacco, Alcohol, and Recreational Drugs: The clinician or healthcare professional assess adults with T2D for use of tobacco, alcohol, and other recreational drugs and should counsel them on how using these substances can adversely impact management of type 2 diabetes.

Strong recommendation **based on randomized controlled trials, systematic reviews, and observational studies with a preponderance of benefit over harm.**

Evidence profile:

- Aggregate evidence quality: Grade B, based on 3 RCTs, 3 systematic reviews, and 1 meta-analysis emphasizing the value of counseling on tobacco, nicotine and recreational drugs in adults with T2D
- Benefits: Raising awareness of an issue that might not have been fully appreciated by the patient; identifying opportunities to reduce harmful habits; triaging patients for smoking cessation programs, identify alcohol use disorder
- Risk, harm, cost: Perception of being judgmental, potential harm to clinician-patient relationship
- Benefits-harm assessment: Preponderance of benefit over harm
- Intentional vagueness: The term "recreational drugs" is intended to include a variety of products

Value judgments: None

Alcohol Use Disorders Identification Test

The Alcohol Use Disorders Identification Test (AUDIT-C) is an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence).

Q1: How often did you have a drink containing alcohol in the past year?

Answer	Points
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4

Q2: How many drinks did you have on a typical day when you were drinking in the past year?

Answer	Points
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4

Q3: How often did you have six or more drinks on one occasion in the past year?

Answer	Points
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

NIDA Quick Screen

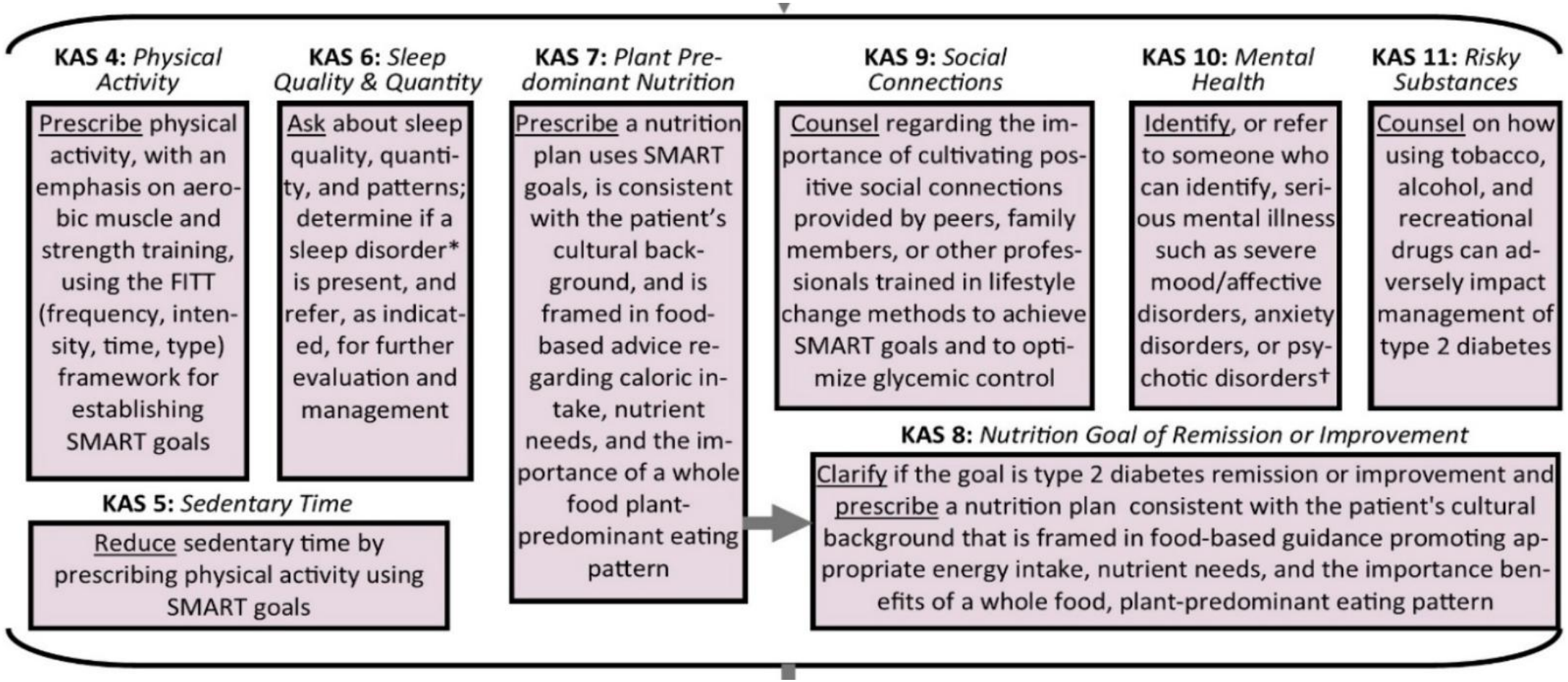
Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA Quick Screen Question: In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- *If the patient says "NO" for all drugs in the Quick Screen, reinforce abstinence.*
- *If the patient says "Yes" to one or more days of heavy drinking, patient is an at-risk drinker. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to Assess, Advise, Assist, and Arrange help for at risk drinkers or patients with alcohol use disorders*
- *If patient says "Yes" to use of tobacco: Any current tobacco use places a patient at risk. Advise all tobacco users to quit. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm*
- *If the patient says "Yes" to use of illegal drugs or prescription drugs for non-medical reasons, proceed to Question 1 of the NIDA-Modified ASSIST.*

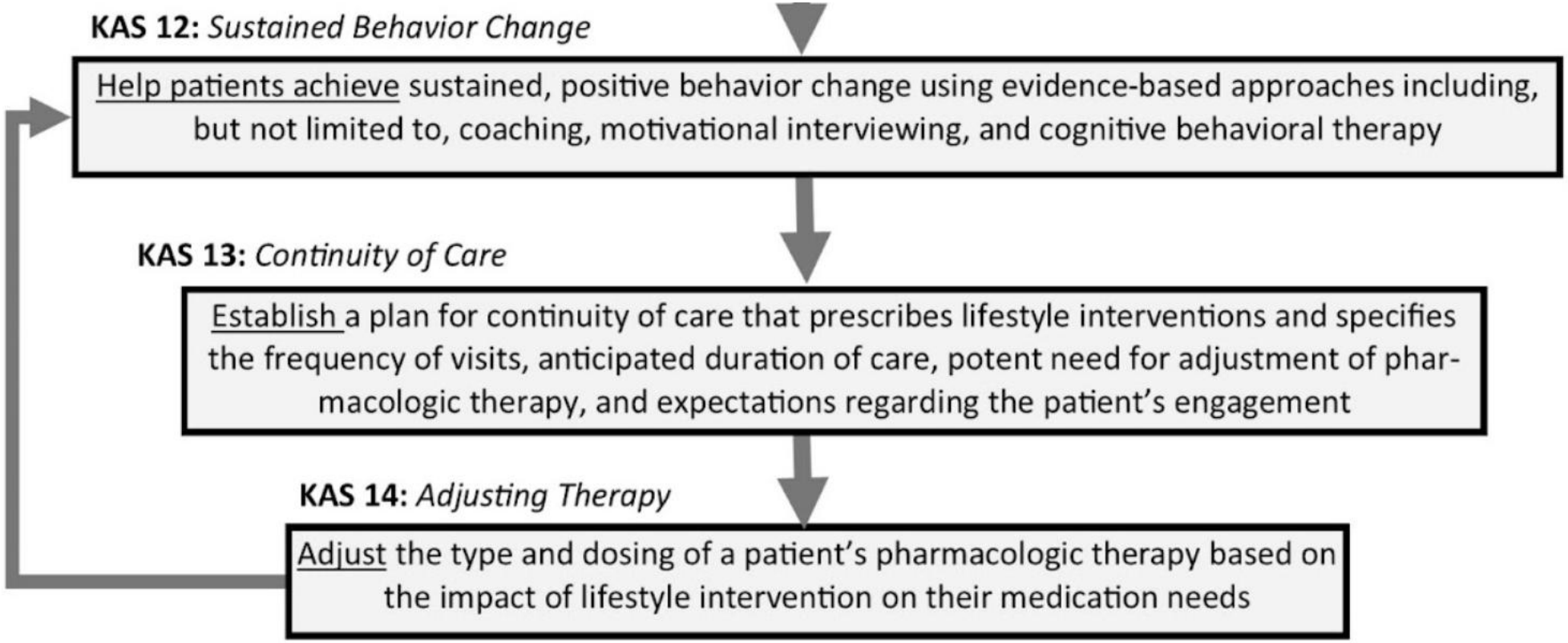
Bush K, et al. The AUDIT alcohol consumption questions (AUDIT-C). Arch Int Med 1998; 158:1789-95; National Institutes on Drug Abuse, NIDA Quick Screen v1.0 2024; .
https://nida.nih.gov/sites/default/files/pdf/nmassist.pdf

Summary of Lifestyle Intervention Statements

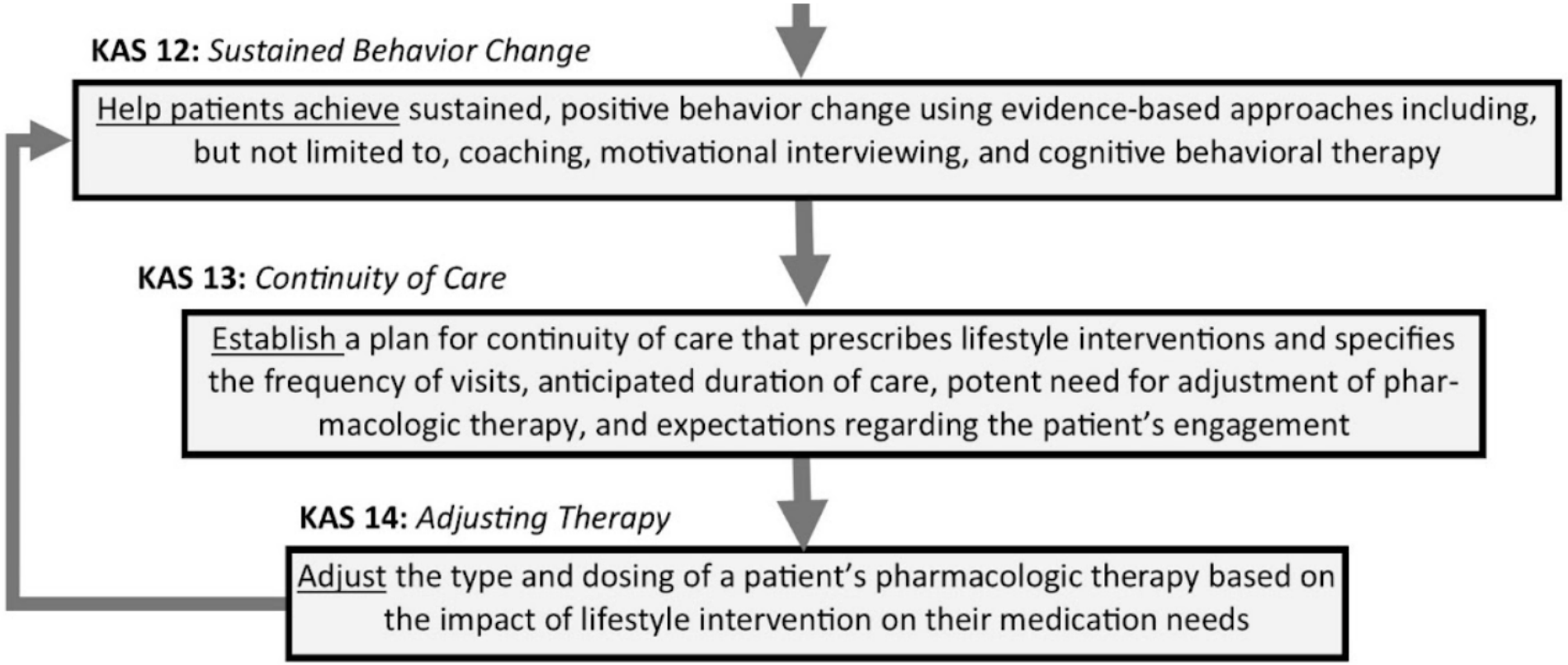


Behavior Change, Continuity of Care, Deprescribing

The Last 3 Key Action Statements in the Guideline



Lifestyle Interventions for Diabetes Flowchart (3)



Rosenfeld RM, et al. Clinical Practice Guideline: Lifestyle Interventions for Diabetes in Adults (Draft)

AMERICAN COLLEGE OF Lifestyle Medicine

Deprescribing Approach

STARTING POINTS

Hypoglycemia-causing drugs

1. Sulfonylureas
2. Insulin
3. Meglitinides, non-sulfylnurea insulin secretagogues

Nonhypoglycemia-inducing drugs

1. Metformin
2. GLP-1 receptor or GIP-GLP-1 receptor agonists
3. SGLT-2 inhibitors
4. DPP-4 inhibitors
5. Acarbose
6. TZDs

Determine lifestyle dosing

CGM

Self-testing >1x/day

Hypoglycemia-causing drug

1. Stop sulfonylureas and meglitinides first if someone is embarking on an intensive lifestyle (esp. dietary) modification
2. Insulin:
   - Reduce dosage when the patient's post-prandial and fasting blood glucose is close to target.
     - (eg., When the patient's postprandial target is 140 mg/dL - reduce insulin dosage when the patient's PP glucose is around 180 mg/dL)
   - If glucose are >250 post-prandial or >180 fasting, then reduce <=10%, monitor symptoms and glucose preferably via CGM or 4x/day if CGM not available
   - If glucose consistently <150, then fasting or postprandial patient is at risk for hypoglycemia, therefore:
     - decrease insulin substantially, at least 20-40% and then monitor via CGM or 4x/day if CGM not available
   - Consider switching to long acting basal insulin analogs like glargine or degludec or detemir in place of neutral protamine Hagedorn insulin to avoid nocturnal hypoglycemia

Non-hypoglycemia-causing drugs

1. Deprescribe based on cost considerations first, then second drugs that are DPP-4 inhibitors and acarbose because of the lack of other benefits
2. If blood sugars are at target based on considerations in slide 3, then may be able to taper down

Monitoring and further deprescribing during active intervention period, CGM whenever possible

Monitoring and maintenance, frequency and method set by clinician

Mannucci E, et al. Efficacy and safety of different basal and prandial insulin analogues for the treatment of type 2 diabetes: a network meta-analysis of randomized controlled trials. Endocrine 2021; 74:508-17.

KEY TAKE-AWAY POINTS, AND A VISION FOR THE FUTURE

- We set out to create a pragmatic, action-oriented, and implementable CPG document that would be immediately relevant to your healthcare landscape and day-to-day practice.
- Proposal for a systematic, evidence "Guideline directed Lifestyle Therapy" implementation framework, which opens the door for other chronic conditions too, not just prediabetes and T2D
- The 6 pillars or LM are key, but equally important are HCP advocacy, baseline assessment, readiness to change, sustaining change, and continuity of care.
- What the future holds: design thinking, using advance tech tools including AI, habit science and design, role of social media including misinformation and disinformation, etc.

What's *new* compared with traditional diabetes guidelines

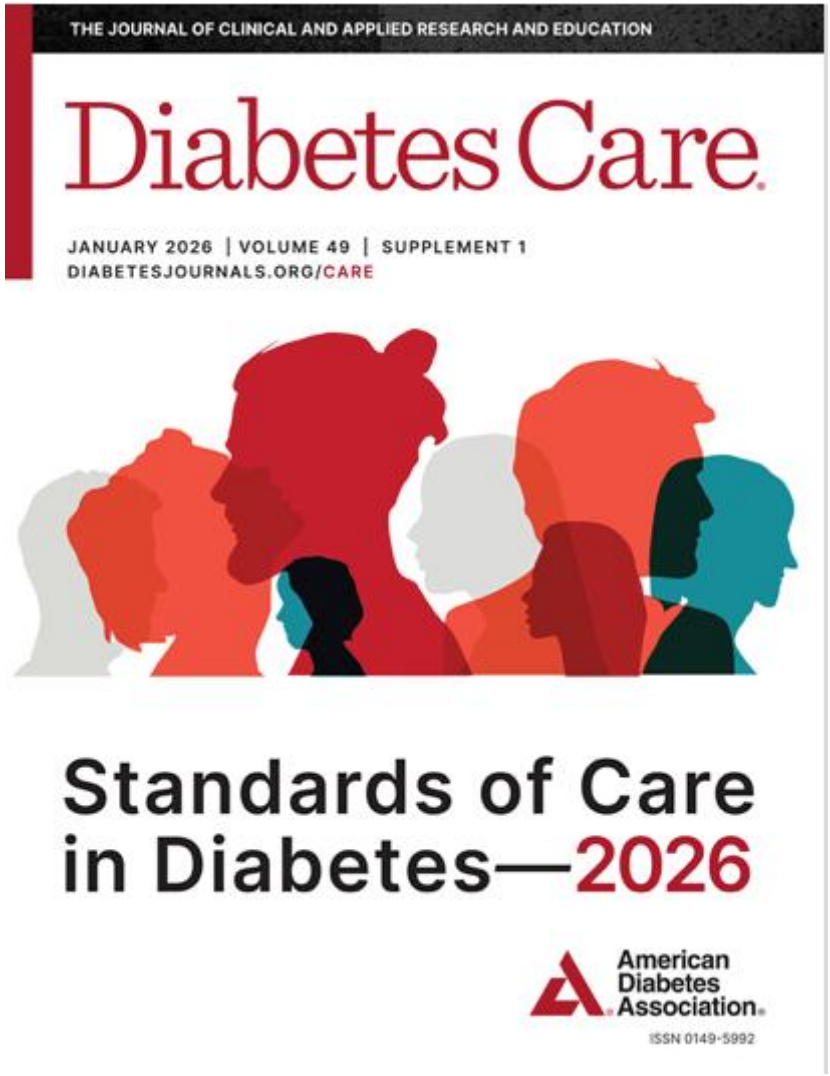
- **Remission as a primary goal** – reflected in nutrition KAS 8 and deprescribing KAS 14.
- **Operational detail:** Each pillar comes with ready-to-use FITT tables, SMART-goal worksheets, and example nutrition prescriptions—addressing a long-standing "implementation gap" noted in ADA and AACE documents.
- **Behavioral science integrated:** Guidance on motivational interviewing, health coaching, and group visits is embedded, not relegated to appendices.
- **Quality-improvement hooks:** Every KAS contains a metric (e.g., "% of patients with documented sleep assessment") to facilitate audit-and-feedback cycles.
- **Plain-language & CME add-ons:** Companion patient summary and 3.75 CME course support rapid uptake American College of Lifestyle Medicine .

Why it matters	First national guideline to put **lifestyle medicine's six pillars** (plant-predominant nutrition, physical activity, restorative sleep, stress management, social connection, avoidance of risky substances) **ahead of drugs or devices** as the therapeutic foundation and a realistic path to remission American College of Lifestyle Medicine Guideline Central

Bottom line:

ACLM's 2025 guideline reframes diabetes and pre-diabetes care around *treat-to-remission* lifestyle medicine. It supplies clinicians with graded evidence, concrete action steps, and deprescribing guidance—filling a practical gap left by larger, pharmacology-centric standards.

Bringing the “what” and the “how” together



American Journal of Lifestyle Medicine Jul 2025

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Clinical Practice Guideline

Lifestyle Interventions for Treatment and Remission of Type 2 Diabetes and Prediabetes in Adults: A Clinical Practice Guideline From the American College of Lifestyle Medicine

This guideline has been endorsed by the American Association of Clinical Endocrinology, American Academy of Physician Associates, American Association of Nurse Practitioners, American College of Clinical Pharmacology, Obesity Medicine Association, American Academy of Sleep Medicine, Association of Diabetes Care & Education Specialists, and National Board of Health and Wellness Coaches. It has been designated with an “Affirmation of Value” from the American Academy of Family Physicians and is supported by the Academy of Nutrition and Dietetics.

Limit Alcoholic Beverages

- Consume less alcohol for better overall health.
- People who should completely avoid alcohol include pregnant women, people who are recovering from alcohol use disorder or are unable to control the amount they drink, and people taking medications or with medical conditions that can interact with alcohol. For those with a family history of alcoholism, be mindful of alcohol consumption and associated addictive behaviors.

Alcohol	If you drink alcoholic beverages, do so in moderation. 1-2 drinks daily appear to cause no harm in adults	If you drink alcoholic beverages, do so in moderation, which is no more than 1 drink a day for women and 2 drinks a day for men					Adults of legal drinking age can choose not to drink, or to drink in moderation: 2 drinks or less for men and 1 drink or less for women on days when alcohol is consumed.
		Consumption is not recommended		Moderate alcohol consumption may have beneficial effects in some individuals	Not recommended to begin drinking on the basis of potential health benefits	Not recommended to begin drinking for any reason	

The new US DGA (Dietary Guidelines for Americans)

Table. Major Updates in the 2025-2030 Dietary Guidelines for Americans (DGAs)

Recommendations[a]	Implications
• Avoid foods that are highly processed, packaged, or ready to eat • Avoid other foods that are salty or sweet	• Prior DGAs generally presented all food choices as acceptable within overall daily nutrient limits; an approach that was inconsistent with the evidence for harms of certain types of products • No prior DGA has emphasized the dimension of processing separately from nutrients or food groups • This update directly challenges widespread industry products and practices
• Avoid sugar-sweetened beverages • Limit added sugars to no more than 10 g per meal and, in foods, to the US Food and Drug Administration healthy rule (eg, 5 g in grains, 2.5 g in dairy) • No added sugars from birth through 10 y of age	• The 2010 DGA advised against sugar-sweetened beverages, but this recommendation was dropped in subsequent updates • The new recommendations for sugar-sweetened beverages and added sugars are much stronger than in prior editions
• Limit foods and beverages that include artificial flavors, petroleum-based dyes, artificial preservatives, and low-calorie nonnutritive sweeteners	• Although evidence on these additives remains limited and conflicting, emerging studies suggest potential adverse effects on glucose control, microbiome composition, child behavior, and other outcomes • No prior DGAs have recommended their avoidance; indeed, some prior DGA educational materials have promoted nonnutritive sweeteners as a sugar-reduction strategy • The impact will greatly depend on how this is communicated to the public and implemented in agency policy (eg, school meals, early childcare, military nutrition, federal cafeterias)
• Prioritize fiber-rich whole grains • Significantly reduce highly processed, refined carbohydrates	• No prior DGAs have recommended reducing processed or refined carbohydrates (eg, refined wheat, rice, or corn flour); prior DGAs only recommended to partly replace refined grains with whole grains • The new recommendation to significantly reduce refined carbohydrates (roughly 1 in 4 calories in the food supply) is a major change

Mozaffarian D. The 2025-2030 Dietary Guidelines for Americans. *JAMA*. Published online January 14, 2026. doi:10.1001/jama.2026.0283

• Incorporate healthy fats from whole foods such as meats, poultry, eggs, seafood, nuts, seeds, full-fat dairy, olives, and avocados • When consuming dairy, include full-fat dairy with no added sugars • Saturated fat consumption should not exceed 10% of calories	• An emphasis on healthful fats from whole foods could be beneficial, especially if replacing highly processed foods rich in refined carbohydrates, salt, and other additives • Health gains will be greatest if this is translated into foods most strongly linked to health benefits and currently underconsumed by individuals in the US, such as plant and seafood sources • It is unclear how the contradiction will be handled between encouraging full-fat dairy, which is not linked to cardiometabolic harms, and retaining the saturated fat limit (eg, dairy fat could be excluded from the limit as was done for whole milk when it was allowed back into schools as part of the Whole Milk for Healthy Kids Act of 2025)
• Prioritize protein foods at every meal • Consume a variety of protein foods from animal sources, including eggs, poultry, seafood, and red meat, and a variety of plant-sourced protein foods, including beans, peas, lentils, legumes, nuts, seeds, and soy • Aim for protein consumption of 1.2 to 1.6 g/kg of body weight per day	• At a time when most individuals already consume enough protein, this represents a 50% to 100% increase from the current Dietary Reference Intake • If combined with regular strength or resistance training, protein can help build muscle; however, without such training, excess protein can be converted to fat by the liver, increasing visceral adiposity and diabetes risk • Although the DGAs recommend both plant and animal whole foods as protein sources, the higher protein target may result in increased consumption of red meat rather than other more healthful protein sources or consumption of more highly processed foods fortified with protein, which are already rapidly gaining market share • The lack of guidance to limit processed meats, which have been linked to cancer, diabetes, heart disease, and stroke, is an important continuing omission from prior DGAs
• Provides new food pyramid graphic	• A new triangular graphic depicts an abundance of minimally processed foods, including frozen and canned options, organized around 3 points: protein, dairy, and healthy fats; vegetables and fruits; and whole grains • This signals a visual shift from MyPlate, which was a circular graphic without food images and sections representing fruits, vegetables, grains, protein foods, and dairy • The depicted foods in the new graphic and their relative amounts are quite similar to prior MyPlate expanded graphics that included food images, except for more refined grains and flavored low-fat dairy in the MyPlate graphics

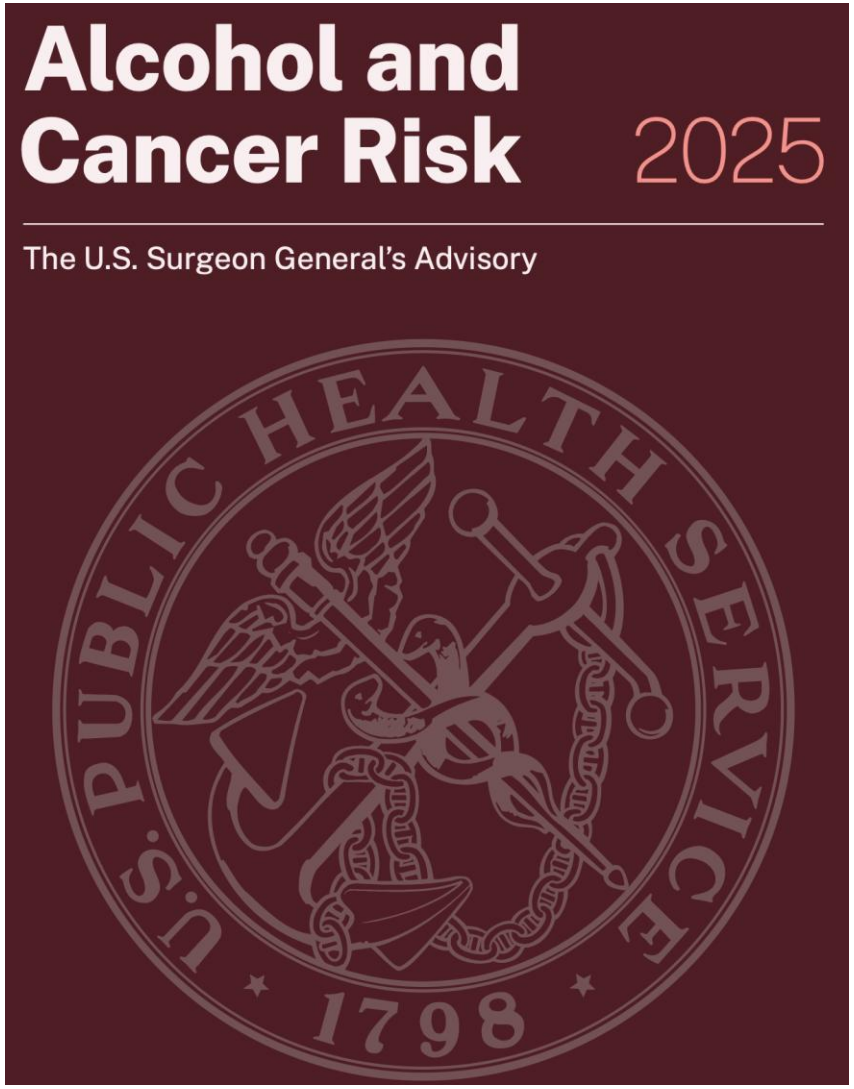
[a] Other changes include (1) new guidance that individuals with certain chronic diseases may experience improved health outcomes when they follow a lower carbohydrate diet and are recommended to work with a health care professional to identify and adopt a diet that is appropriate and (2) the specific limits for alcohol use (≤2 drinks/d for men and 1 drink/d for women) were replaced by a more general statement to "consume less alcohol for better overall health."[1]

How about alcohol?

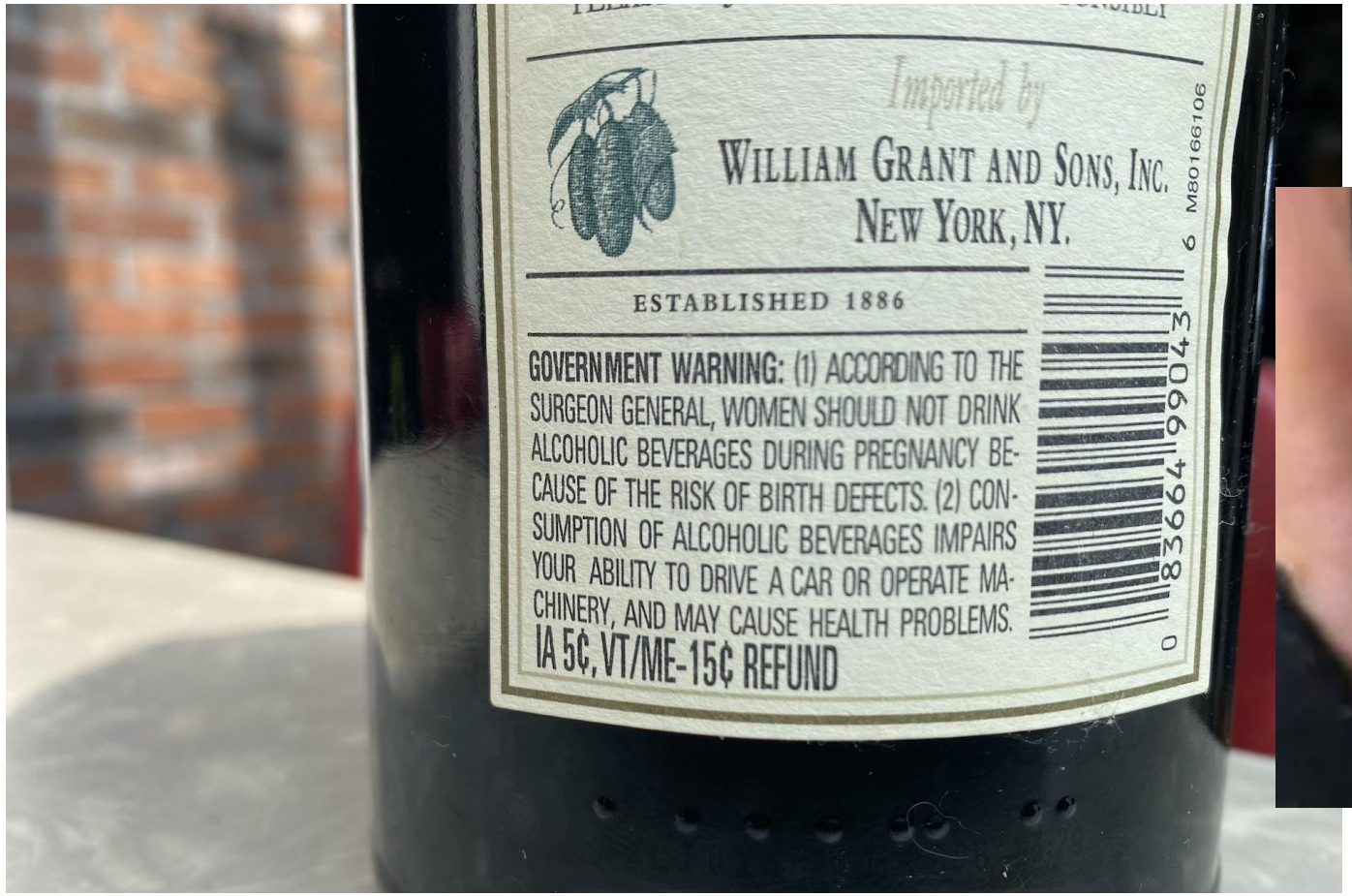
The New York Times

Surgeon General Calls for Cancer Warnings on Alcohol

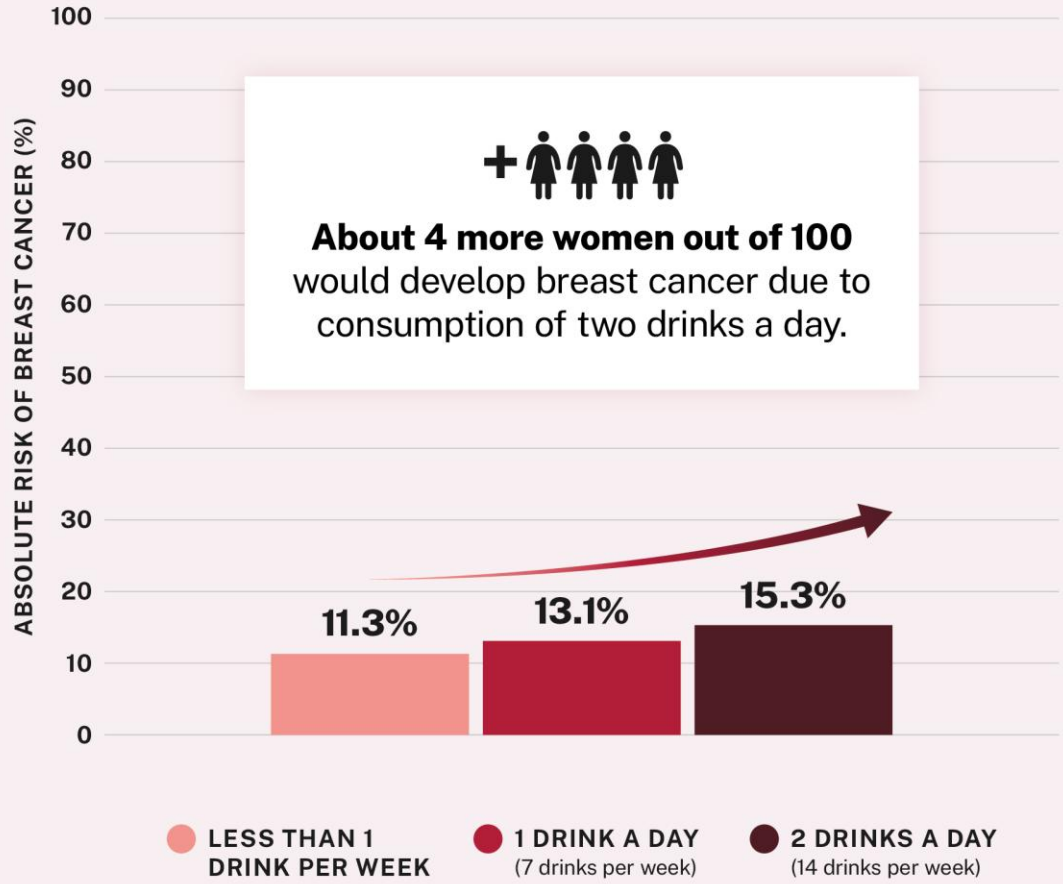
Dr. Vivek Murthy's report cites studies linking alcoholic beverages to at least seven malignancies, including breast cancer. But to add warning labels, Congress would have to act.



Label on consumer products?



Higher alcohol consumption increases breast cancer risk in women



This graph represents the cumulative absolute risk of breast cancer in women over the lifespan by age 80.

Source: *Calculated with data from* Sarich, P., Canfell, K., Egger, S., Banks, E., Joshy, G., Grogan, P., & Weber, M. F. (2021). Alcohol consumption, drinking patterns and cancer incidence in an Australian cohort of 226,162 participants aged 45 years and over. British journal of cancer, 124(2), 513–523. https://doi.org/10.1038/s41416-020-01101-2

Office *of the* U.S. Surgeon General

Thank You!

To Receive Your CE Certificate

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- A link to an evaluation will be sent within a day or two.
- RNs must complete the evaluation to receive CE certificate.
- RD/RDNs: Although completing an evaluation is not required, we truly appreciate your feedback.

  If you do not see the evaluation, look in your spam folder.
- CE certificates for RDs/RDNs/DTRs will be emailed once CPEU approval for this activity is received from CDR.

Next Up: MCNER Webinar Series

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Omega-3s and Cardiovascular Disease Prevention

Carl “Chip” Lavie, Jr., MD, FACC, FACP, FCCP

Wednesday, 2/4/26
12-1 PM ET

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1 CPEU RDs/DTRs
1 contact hour RNs/NPs

Q&A

Moderator:
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