AAFP

Scaling Whole Health Strategies in Primary Care:

ACTION BRIEF

February 2026

ACKNOWLEDGMENTS

We extend our sincere appreciation to all participants of the Scaling Whole Health Strategies in Primary Care Summit, hosted by the American Academy of Family Physicians (AAFP) held November 5-6, 2025. The rich insights and candid discussions of summit participants—physicians, researchers, policy leaders, community partners and system innovators—strengthened the collective understanding of what it will take to advance whole health and person-centered care nationwide.

We extend special appreciation to the Advisory Committee (bolded in the list below), whose expertise, guidance and thoughtful stewardship shaped the vision and direction of the event and this report. We also gratefully acknowledge X4 Health for their consulting expertise, facilitation and ongoing support throughout the entire process, as well as the AAFP staff whose commitment to our mission made this effort possible.

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INTRODUCTION

Primary care is the cornerstone of a high-performing health system. By fostering deep, longitudinal and trusted relationships, primary care has demonstrated its ability to drive better health outcomes for patients and communities. While the current U.S. framework incentivizes the identification and treatment of disease, primary care uniquely focuses simultaneously on prevention and treatment. As interest grows in shifting the system's focus from treating illness to achieving overall health, primary care is poised to lead this transformation.

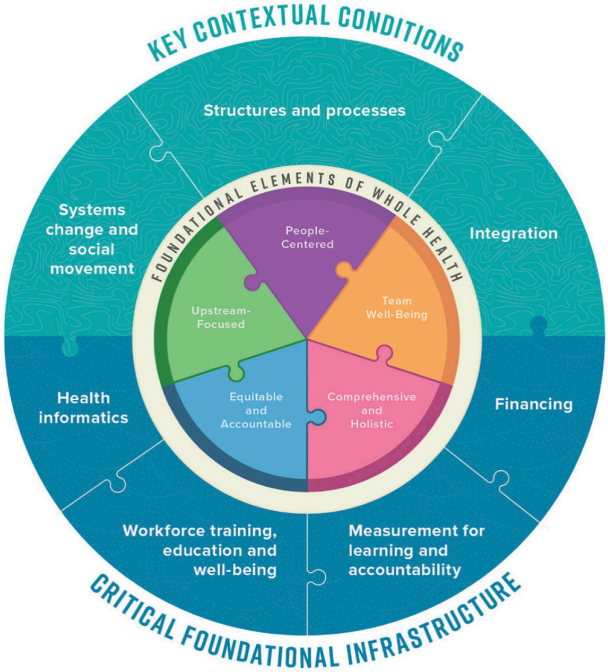
Rationale for action

Despite its vital role and natural alignment with whole health approaches, primary care remains underfunded and overburdened.[1] Integrating whole health strategies into primary care offers significant opportunities to advance evidence-based prevention, improve population health and reduce chronic disease.[2] Efforts such as lifestyle medicine, integrative medicine and functional medicine share primary care's commitment to prevention—promoting better nutrition, regular physical activity, improved sleep, effective stress management and strong community connections. These disciplines also emphasize interprofessional teamwork and a patient-centered approach with a focus on individual needs and goals.

> Care begins with the person and their family, not with the question, 'What is wrong with you today?' Instead, we ask, 'What are your aspirations? What do you want to achieve, and how can we help you get there?'
>
> – Summit participant

Recent consensus reports from the National Academies of Sciences, Engineering, and Medicine (NASEM) provide common whole health definitions and frameworks as a useful starting point for charting a shared path toward meaningful change.

As previously noted, primary care occupies a unique position in the health care system, delivering both prevention and treatment through a whole-person health approach. The American Academy of Family Physicians (AAFP) has consistently equipped its members with policies and resources to support



"Whole health is physical, behavioral, spiritual and socioeconomic well-being as defined by individuals, families and communities. Whole health care is an interprofessional, team-based approach anchored in trusted longitudinal relationships to promote resilience, prevent disease and restore health."[3]

"High-quality primary care is the provision of whole person, integrated, accessible and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families and communities."[4]

evidence-based patient care, including strategies from lifestyle and integrative medicine. Although more primary care practices are adopting these approaches—leading to healthier patients and more satisfied care teams—widespread adoption remains challenging due to factors identified in the NASEM reports.

To address these barriers, the AAFP is collaborating with a broad coalition of health care leaders to explore how payment models and workforce training can enable, rather than hinder, the expansion of whole health strategies in primary care. In November 2025, the AAFP convened the Scaling Whole Health Strategies in Primary Care Summit, supported by the Ardmore Institute of Health (AIH) and the Healing Works Foundation. The summit brought together more than 50 stakeholders—patients, consumer advocates, family physicians, public health leaders, payers, health systems, researchers and policymakers—for a one-and-a-half-day collaboration. The summit aimed to:

- Identify commonalities across primary care models and disciplines that incorporate whole health strategies, such as lifestyle and integrative medicine, as well as advanced team-based care—whether facilitated by fee-for-service (FFS) or value-based payment (VBP) models.
- Identify current enablers and barriers in health care payment.
- Identify physician and care team training resources that facilitate the implementation of whole health care strategies in primary care.
- Identify recommended actions to ensure primary care practices are well-equipped to fulfill their essential role in a whole health-oriented system.

This action brief synthesizes the summit's key insights and presents a strategic roadmap for operationalizing these changes across the health care ecosystem. It incorporates the experiences of all participants represented at the summit, including the following case study participants discussed in greater detail in Appendix A:

- Carilion Clinic
- Fairfax Family Practice Centers
- Kellyn Foundation
- Mary's Center
- Veteran's Health Administration

CURRENT LANDSCAPE AND BARRIERS TO IMPLEMENTATION

Summit participants identified several critical barriers that must be addressed to achieve widespread adoption of whole health strategies in primary care:

1. **Misaligned financial incentives:** The U.S. health care payment systems—FFS and VBP—are fundamentally oriented around identifying and treating illness. Organizational incentives do not align with the work required to support patients' holistic health care journeys. Primary care is well-positioned to support patients' achievement of whole health, but it is the least-resourced aspect of the overall system as it exists today.[1]

> We don't want just value-based medicine...we want **values**-based medicine.
>
> – Summit participant

2. **Workforce preparedness and educational gaps:** Medical training and residency programs often emphasize acute diagnosis and treatment, leaving clinicians less prepared to implement whole health modalities. Many lack confidence in using tools such as nutrition education, mind-body practices and health coaching. Additionally, there is a gap between training environments and real-world practice, where integrated teams and resources may be unavailable.

3. **Lack of supportive practice structures:** Existing care delivery models, built around time-limited encounters and high-throughput workflows, are not conducive to whole health strategies. These structures lack the flexibility needed for deep, relational care that addresses patients' holistic needs.

4. **Behavioral and cultural inertia:** Shifting to a whole health approach may require a fundamental change in mindset and behavior for physicians, care teams and patients. Moving from episodic, acute care to collaborative, coaching and team-based models is challenging without strong champions and significant investment in change management and implementation science.

5. **Siloed initiatives:** Addressing these complex challenges demands coordinated efforts to realign payments and other incentives, as well as to share best practices for redesigning workflows and supporting cultural change. However, many organizations continue to pursue individual agendas rather than a unified approach to whole health strategies and outcomes.

6. **Interoperability and data challenges:** Achieving whole-person health in primary care is hindered by a fragmented data infrastructure. As strategies such as lifestyle medicine and "food is medicine" attempt to integrate data from community partners, current systems struggle to share information seamlessly across clinical, administrative, payer and community platforms. This fragmentation increases administrative burden and limits access to meaningful outcomes data needed to demonstrate value.

KEY ENABLERS OF WHOLE HEALTH SCALABILITY

A central aim of the summit was to identify practical solutions to overcome systemic challenges. Participants highlighted approaches used by leading organizations to illustrate how health systems can put whole health into practice by leveraging workforce innovation, incorporating team-based care and developing community partnerships. Drawing on these examples and other insights shared during the summit, several key enablers for scaling whole health emerged.

1. **Workforce training and development:** Sustainable whole health implementation requires shifting the workforce mindset and providing meaningful training opportunities. For example, the Veterans Affairs (VA) system successfully trained 65% of its primary care teams using a two-hour virtual foundational course in whole health.[5] Carilion Clinic leverages its operations within a family medicine residency program to train future generations of physicians by providing experiential learning opportunities.

2. **Focus on team well-being:** Successful implementation of the whole health model requires healthy, functional people and teams. To mitigate burnout, organizations must invest in the well-being of the care team. Mary's Center utilizes a "Meaning, Mastery and Membership" framework to connect staff to a shared purpose and provide a supportive environment. The VA supports well-being through "Communities of Practice," which fosters a sense of shared mission among staff.

3. **Redesigned care delivery models:** Effective models move beyond the physician-centric encounter to leverage a broader, multi-disciplinary team-based approach. The VA has established a network of more than 520 Whole Health Integration Champions—including physicians and non-physician staff, such as nurses and pharmacists—who are empowered to drive the model locally. Carilion Clinic utilizes a hub-and-spoke model in which physicians serve as the lead but rely on a "resource bank" with educational materials for patients. This allows for immediate handoffs to on-site pharmacists, community health workers and behavioral health specialists.

> "If you look at those five foundational elements of whole health, there is no team member who can do them all. Whole health is a team sport."
>
> – Summit participant

4. **Financial viability through strategic billing:** While FFS payment remains a challenge, organizations are finding ways to sustain whole health within current payment structures. Carilion Clinic and Kellyn Foundation successfully utilize time-based billing codes to reimburse for the longer, more complex conversations required to support significant behavior change in patients. Both organizations also leverage group visits as an efficient and effective way to deliver education and coaching to multiple patients simultaneously while maintaining billable encounters.

5. **Community integration and cross-sector partnerships:** Truly holistic care extends beyond the clinic walls, requiring integration with sectors that address upstream determinants of health. Mary's Center co-locates clinical services with a public charter school, integrating medical, social and educational services. Kellyn Foundation uses schools and community gathering places as hubs to deploy interventions, such as mobile food markets. By partnering with local health bureaus and state departments, these organizations extend the reach of health care into the patient's community.

> We're trying to make denominator doctors. Yes, they see the patient in front of them, and they see the community from where they came. But what about the patients from that same community who are not coming in?
>
> – Summit participant

SUMMIT VISION

The vision shaped by summit participants has the potential to yield significant benefits for a multitude of stakeholders across our health care ecosystem. Successfully implementing the roadmap recommendations that follow can impact the following audiences in several important ways:

Patients

- *Improved access:* Affordability barriers (e.g., copays) are eliminated, and the clinician workforce supply stabilizes and expands as a result of higher professional well-being enabled by whole health approaches.
- *More equity:* Social drivers of health are actively addressed, leading to more equitable care.
- *Better patient care and health outcomes:* Patients, especially those with chronic diseases, receive proactive, team-based support, leading to improved quality of life.
- *Improved patient satisfaction:* Care is person-centered and relational, not transactional. Patients are asked, "What matters to you?" and have the time to build trust with their care team.

Clinicians and care teams

- *Reduced burnout and moral distress:* Clinicians can practice the team-based, comprehensive medicine they were trained to deliver, leading to improved professional satisfaction.
- *Sustainable workflows:* The burden of care is shared across an integrated, well-resourced team, allowing physicians to work at the top of their license.
- *Restored "joy in practice":* The focus shifts from relative value unit-driven productivity to the more fulfilling, mission-oriented work of co-creating health with patients.

Health systems and payers

- *Reduced total cost of care:* An upfront investment in prevention yields significant downstream savings by reducing high-cost, avoidable utilization.
- *Lower the high-cost utilization of health care:* Measurably reduce emergency department visits, hospital readmissions and the need for expensive specialty procedures.
- *Stable primary care workforce:* A more professionally rewarding and sustainable practice model will help recruit and retain a steady primary care workforce, ensuring the long-term stability of the entire health care system.

ROADMAP OF PRIORITIES AND ACTION STEPS

To identify ways to scale and spread whole health strategies, summit participants worked together to identify key priorities and action steps, along with building blocks that can facilitate progress. The priorities are intentionally organized by scope, beginning with immediate interventions that practices can spearhead and expand to address the broader financial, regulatory and training landscape, which policymakers and others will need to address over time.

Payment and financing

Summit participants identified misaligned incentives as a significant barrier to scaling whole health strategies. While VBP offers promise, incentives remain limited in scale and are often too small to drive meaningful change. Further, VBP incentives do not always trickle down from the organizational level to the clinic or practice setting, creating a critical disconnect. For example, health systems may receive VBPs, but in many cases, individual physician performance and compensation remain tied to volume-driven productivity goals.

To bridge this gap, summit participants emphasized the need for a dual strategy. This includes advocating for permanent structural changes to payment models while accelerating the adoption of existing mechanisms and innovative care delivery approaches.

Payment and financing roadmap

Key actors – Public and private payers, health systems and medical groups

Act now priorities (1-3 years to impact)	Action steps and resources
Build the business case Show the value of whole health strategies in both financial and non-financial terms and share the many available resources/ examples of success to gain buy-in from health system leaders, payers and policymakers. Emphasize outcomes such as fewer emergency department visits, reduced opioid prescribing, improved patient health and loyalty, and enhanced care team well-being, leading to lower staff turnover.	• Leverage the Shared Principles of Primary Care, established in 2017 and signed onto by hundreds of organizations • Position the whole health model as a key solution for mitigating clinician burnout • Share case studies of practices implementing whole health strategies and their impact, such as the VA Whole Health System, Mary's Center and Southcentral Foundation's Nuka System of Care • Use existing tools to assess clinician well-being, such as the American Medical Association's (AMA's) Mini-Z Worklife and Burnout Reduction Instrument or the Mayo Clinic's Well-Being Index • Use existing tools that help discuss whole health with patients (e.g., VA's Well-Being Signs measurement) • Use existing measures to assess impact on patients (e.g., the Larry A. Green Center's Person-Centered Primary Care Measure, Whole Person Health Index and the PROMIS Global Health Scale) • Use existing resources such as the Healing Works Foundation's HOPE Note tool • Identify existing measures that capture these improvements and map them to desired outcomes (e.g., improvements in value-based contractual results, improved staff satisfaction, reduced turnover and patient loyalty)
Ensure existing payment mechanisms are fully implemented Time-based billing and Advanced Primary Care Management (APCM) service codes are payment mechanisms that can support whole health care strategies in primary care. However, these codes are underutilized in many practice settings. Utilizing these mechanisms can provide the revenue to support whole health implementation. • **Time-based billing** Allows clinicians to bill accurately for patients who require extended discussions for education and/or care coordination. It covers the total time spent in a day, including pre-visit preparation, documentation and patient communication—giving flexibility to prioritize each patient's unique needs. • **APCM codes** Introduced in the Medicare Physician Fee Schedule in January 2025, APCM bundles primary care services to simplify billing and documentation. By using a tiered approach based on patient complexity, practices can reinvest APCM revenue into whole health strategies (e.g., hiring a social worker).	• Investigate and address barriers to using time-based billing and APCM codes • Access existing guidance on time-based billing and APCM: – AAFP's Medical billing and coding resources – AAFP *FPM* article, Outpatient E/M coding simplified – AAFP *FPM* blog post, Tips for time-based coding – AAFP's Using Advanced Primary Care Management Codes – CMS's FAQs on Advanced Primary Care Management Services – ACP's Coding for clinicians • Equip clinicians with the tools and knowledge needed to accurately and efficiently code for their visits • Advocate collectively with other primary care and patient organizations to remove monthly patient copays for APCM enrollment
Implement shared medical appointments (SMAs) Shared medical appointments (SMAs) (also called group visits) allow a physician to work with multiple patients with similar health conditions at the same time in a group setting. This can be an effective tool for patient engagement and improvement, while also providing an efficient way to scale whole health strategies across any primary care setting.	• Utilize the Whole Person Health Index (developed by the National Center for Complementary and Integrative Health and the National Center for Health Statistics/CDC) to assess the overall status of your patients • Assess the alignment of your patient population with SMA/group visits, considering such factors as common chronic conditions and patient interest/openness to group visits • Identify and train staff to facilitate group visits • Utilize available resources: – Staff trainings (e.g., Ardmore Health Institute's (AHI's) SMA programs and CME training and SMA facilitator training) – General whole health tools and resources (e.g., AAFP's Whole Health Guide, AHI's CME on implementing SMA utilizing Full Plate Living) – Integrated Center for Group Medical Visits' Resources for Group Visits • Payment guidance (e.g., AAFP's Coding for group visits, American College of Lifestyle Medicine's (ACLM's) Reimbursement Resources and Shared Medical Appointments Toolkit)

Payment and financing roadmap

Key actors – Employers and unions (health care purchasers), health systems, medical groups/practices

Act now priorities (1-3 years to impact)	Action steps and resources
• **Direct primary care (DPC)** is a practice model that operates outside traditional insurance, in which patients pay their physicians and other clinicians a flat recurring or annual fee directly for primary care services. This model offers greater flexibility, including longer visits, enabling physicians and other clinicians to focus on aspects of whole health care, such as prevention, nutrition and behavioral health. • **Employer direct contracting** is an underutilized but growing opportunity for practices to work directly with the employer community. Many employers invest significantly in wellness strategies. Practices can creatively contract with employers to deliver clinical services, including a broad range of whole health interventions focused on healthy behaviors.	• Work through regional employer health care coalitions and engage with the employer community in your market to understand their needs and preferences • Engage employers to share data on employee retention, workers' compensation and health care costs to build a business case for whole health models • Utilize existing resources such as: – AMA's Case studies, custom networks and contract terms: Direct-to-employer arrangements – AMA's Direct-to-employer arrangements model checklist – AAFP's Direct primary care resources – ACP's Direct patient contracting

Key actors – Public and private payers, national legislators and staff

Mid-term priority (3-5 years to impact)	Action steps
• **Lower financial barriers to primary care for patients** • **Cost-sharing is a barrier to implementing whole health strategies in many primary care settings.** Eliminating patient copays would be an important step in improving the adoption and implementation of evidence-based prevention strategies in primary care, including the APCM services.	• Share education regarding the interwoven approach to prevention and treatment in primary care • Collect and disseminate patient stories that illustrate how financial barriers to primary care lead to worse health outcomes and higher costs, which are frequently borne by taxpayers through uncompensated care in emergency departments

Key actors – National regulatory agencies, state legislatures, health care agencies, health plans, state medical organizations, primary care champions, and patient advocates and organizations

Long-term priority (5-10 years to impact)	Action steps and resources
Increase primary care investment and establish clear accountability for achieving improvements in whole health approaches in primary care In the United States, just 5 to 7 cents of every health care dollar is estimated to be spent on primary care.[6] Other high-income countries with much higher-performing health systems spend approximately 13 cents per dollar. Primary care is the platform for delivering whole health-oriented care that helps prevent and reduce disease, improve and sustain good health, and improve health care affordability. Some states have passed legislation and/or established task forces that measure and guide primary care spending targets and measurement efforts. Yet primary care spending has stagnated over time, contributing to fewer resources flowing to primary care practices. This is one of many factors contributing to a decline in the primary care workforce that must be stemmed and reversed.	• Seek national measurement frameworks that can be applied at the state and local levels to ease the burden of these efforts on smaller entities • Ensure states are equipped with the knowledge and information to focus on improvements within their state, with resources such as the Implementing High-Quality Primary Care: A Policy Menu for States (developed jointly by the National Academy for State Health Policy and the Milbank Memorial Fund) • Promote the use of national resources, such as the Milbank Memorial Fund's Primary Care Scorecard Report and Data Dashboard • Embed measures of accountability for primary care spending and resource allocation into all public and private payer measurement mechanisms, as well as health care system certifications

WORKFORCE DEVELOPMENT AND TRAINING

Summit participants reported growing support for whole health as a core competency, with institutions such as the Alice Walton School of Medicine and universities in Arizona and Utah incorporating it into required curricula. These schools teach practical skills, such as health coaching, and they emphasize interprofessional teamwork, treating whole health as a collaborative effort. Hub-and-spoke training models include those for pharmacists, community health workers and behavioral health specialists. To maintain this innovative progress, graduates need team-based support and incentives aligned with their training once they begin their professional medical journey. Scaling whole health also depends on having adequate resources to support care teams in practice.

Workforce development and training roadmap

Key actors – Health systems, medical groups/practices, medical societies

Act now priorities (1-3 years to impact)	Action steps and resources
Facilitate opportunities for practicing clinicians to receive training and gain experience in whole health strategies Physicians and clinicians currently in practice require access to retraining programs that emphasize the practical, operational and financial aspects of implementing whole health approaches. These professionals have distinct needs from new clinician trainees, as their primary objective is to integrate whole health principles into their existing practices.	• Establish neighborhood hubs with groups of physicians and virtual experts with a focus on best practices in practice transformation. Training can be delivered more effectively in local community settings. • Develop strategies (e.g., a whole health toolkit) to fully integrate broader team members (e.g., health coaches, community health workers) into the daily clinic setting (e.g., The Comprehensive Health Integration [CHI] Framework) • Include tools that empower teams and mid-level managers to identify and fix gaps in care and workflow • Provide specific training on billing, coding and other financial and operational strategies and tools (e.g., VA's Whole Health Library, AHI's Lifestyle Medicine and the Primary Care Provider) • Develop CME courses focused on whole health and incorporate them into existing CME offerings, such as those led by specialty organizations (e.g., AAFP's FMX). Health systems can sponsor clinicians in obtaining deeper training, such as fellowships in areas related to whole health (e.g., lifestyle medicine or integrative medicine).

Key Actors: Primary care champions/organizations (e.g., AAFP, ACLM, American Academy of Pediatrics [AAP], Academic Consortium for Integrative Medicine & Health), public health agencies, public and private payers, patient advocacy organizations, interprofessional team member organizations (e.g., Academy of Nutrition and Dietetics, American Public Health Association, American Psychological Association, American Nurses Association, etc.), policy leaders and government officials

Act now priority (1-3 years to impact)	Action steps and resources
Establish a unified leadership coalition for whole health to align and work together toward shared goals An umbrella group of thought leaders from all the organizations involved in whole health would help ensure that organizations are working in alignment to: • Ensure that whole health strategies are spread and scaled • Share consistent messaging about whole health for advocacy purposes • Include whole health in both training and payment models	• Share best practices and approaches to whole health • Establish an advocacy coalition to advance training and payment models and approaches to elevate the value and priority of whole health primary care within primary care organizations • Provide policymakers with access to an integrated whole health educational and competency model • Develop a consensus list of whole health competencies that should be included in medical education (and other health care disciplines) and post-graduate (e.g., residency) training and work with licensing boards to incorporate these competencies in board exams • Adapt graduate medical education (GME) training to encompass whole health, including adequate funding of whole health education and inclusion of other disciplines in residency and schools of medicine faculty, such as dietetics and exercise specialists • Normalize interprofessional education that includes instructors from the disciplines included to model interprofessional teams • Convene primary care disciplines to build consensus on a whole health training approach • Develop talking points on whole health and the ways it can help chronic disease prevention and treatment • Share the work from existing champions of whole health strategies (e.g., VA's Whole Health Integration Champions [WHIC]) • National Council for Mental Well-Being's Partnering with Schools to Improve Youth Mental Health

Key Actors: Trainee and medical student organizations (e.g., Family Medicine Interest Groups [FMIGs], Health Occupations Students of America [HOSA], residency programs), primary care champions/organizations (e.g., AAFP, AAP, American College of Physicians [ACP])

Mid-term priority (3-5 years to impact)	Action steps and resources
Embed experiential whole health training across the continuum Training must begin early in medical school and continue throughout residency, with opportunities for experiential learning so trainees can see whole health strategies in practice and better understand how to integrate them into the existing health care system, including working within interdisciplinary care teams.	• Create experiential learning opportunities for trainees, both virtually and in person (e.g., by facilitating SMAs) • Consolidate curriculum from existing bright spots to avoid reinventing the wheel (e.g., medical school curriculum that integrates whole health, such as the Alice Walton School of Medicine's curriculum, the University of Arizona's Integrative Medicine in Residency curriculum and ACLM's Culinary Medicine Program) • Incorporate existing training programs for other clinicians (e.g., ACLM's Community Health Workers Certificate Program) • Incorporate opportunities for physicians to use and develop tools in the community (e.g., have residents use and update the AAFP's Neighborhood Navigator) • Create avenues to share whole health strategy experiences (e.g., FMIGs or HOSA) • Required curriculum and assessment in undergraduate medical education and GME training to cover whole health in both pre-clinical and clinical coursework that follows established guidelines and assesses related competencies

Workforce development and training roadmap	
Key actors: Medical education accreditation bodies (e.g., Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education); medical education assessment and licensure organizations (e.g., U.S. Medical Licensing Examination, National Board of Medical Examiners); other professional licensing and accreditation boards (e.g., for nurse practitioners); state licensing boards; education and curriculum development organizations (e.g., Association of American Medical Colleges, Society of Teachers of Family Medicine); and advocacy organizations (e.g., Primary Care Collaborative [PCC])	
Long-term priority (5-10 years to impact)	**Action steps and resources**
Integrate and codify whole health as a fundamental approach across primary care education and training settings Whole health should be a fundamental approach to care, woven into all training, rather than an area of specialization that creates fragmentation or the perception that this type of care is not accessible to all primary care practices. This will be key to improving patient care, health outcomes, practice experiences and patient/provider satisfaction.	• Create a working group of educators to define and map core whole health competencies and educational goals across disciplines • Utilize existing competencies and tools available across disciplines (e.g., VA's Whole Health Library, National Center for Integrative Primary Healthcare's resources) • Create a repository of model curricula and a unifying licensure model • Advocate to include whole health competencies in medical school and specialty board exams
Key actors: Primary care champions/organizations (e.g., AAFP, AAP, ACP, PCC, patient advocacy groups, community-based organizations)	
Long-term priority (5-10 years to impact)	**Action steps and resources**
Empower patients to become whole health advocates who build a groundswell of support for and actively seek out whole health in primary care Patients need and want whole health support. Yet currently, there is a lack of understanding and confusing public messages about what whole health is. Providing patients with education and empowering them is important to the overall change process.	• Share unifying messages about whole health that resonate with patients and care teams, using patient stories and testimonials • Create a mechanism to enable practices to self-identify as whole health providers and an accompanying search tool that allows patients to locate practices that promote whole health strategies (e.g., ACLM's Find a Lifestyle Medicine Clinician search tool). • Create a whole health platform which contains language for patients to advocate for themselves (e.g., safest, least invasive interventions first; mind, body and spirit orientation to care)

CONCLUSION

The summit's collaborative efforts have provided a defined path forward for scaling whole health strategies in primary care. By prioritizing workforce development, payment reform and interprofessional teamwork, stakeholders can begin to overcome longstanding barriers and foster a system where disease prevention, patient-centered care and community integration are the standard. The roadmap offers actionable steps for practices, physicians, payers, educators and policymakers to align incentives, redesign care delivery, and empower clinicians, care teams and patients. These changes are essential to build a resilient, equitable and sustainable health care ecosystem that meets the evolving needs of individuals and communities.

As the health care landscape continues to shift, the momentum generated by this summit must be sustained through ongoing collaboration, advocacy and innovation. The case studies that follow demonstrate how organizations are already operationalizing whole health principles, serving as models for broader adoption. By embracing these strategies and committing to shared goals, the primary care community can lead the transformation toward whole health by improving outcomes, patient/clinician satisfaction and well-being for everyone.

While this action brief reflects areas of broad alignment, specific roadmap recommendations have not been endorsed by each participant.

APPENDIX A

Case studies: Whole health primary care strategies in practice

Although the broader U.S. health care system often lacks the foundational elements of whole health, successful exemplar organizations demonstrate a path forward. Representatives from these organizations provided specific, actionable strategies for advancing whole health strategies.

Carilion Clinic

Carilion Clinic, based in Roanoke, Virginia, is a non-profit, integrated health care system home to the nation's oldest family medicine residency program. The system is designed to provide full-scope family care, specifically targeting medically underserved safety-net populations with high rates of Medicaid coverage and chronic disease. Carilion Clinic embeds its clinical practice within a lifestyle medicine residency. This creates a sustainable "hub-and-spoke" model where residents are trained in a team-based environment that includes community health workers and behavioral health specialists. The clinic relies on a resource bank (e.g., handouts for patients on chronic disease management, nutrition education and warm handoffs to team members), ensuring patients receive holistic support without overburdening clinicians. Financially, Carilion Clinic successfully uses time-based billing to sustain the longer, complex conversations required for whole health approaches, demonstrating that high-quality, relational care can be economically viable in an FFS environment.

> "Whole health has made me a believer since the day I started it...my blood pressure is now 106 over 60, and I don't think I'll ever go back on medication—this is a magic wand."
>
> – Patient using the VHA's whole health services

Fairfax Family Practice Centers

Fairfax Family Practice Centers has provided family medicine care in Northern Virginia for more than 50 years. Independently owned and led by physicians, the practice leverages Medicare's APCM services to cover the infrastructure and staff needed to deliver a more holistic, proactive model of care that addresses the full range of a patient's needs. For example, the practice uses Healthcare Common Procedure Coding System code G0557 for patients with two or more chronic conditions expected to last at least 12 months and that place the patient at significant risk. This code yields approximately $48.84 per patient per month (as of the 2025 fee schedule), providing a steady and scalable revenue source for the practice. They have used this revenue to hire individuals with whole health expertise to join their interprofessional team.

Kellyn Foundation

Kellyn Foundation, based in Tatamy, Pennsylvania, is a grassroots organization that leverages schools and community gathering places as hubs for delivering population health interventions. Its Healthy Neighborhood Immersion Strategy emphasizes the implementation of lifestyle medicine programming alongside expanded access to healthy foods through coordinated, community-wide initiatives. Kellyn Foundation serves as a connector among community members, local farmers, educational institutions and the health care system. In partnership with local residency programs, Kellyn Foundation utilizes the lifestyle medicine residency curriculum to train the next generation of physicians, an approach that also functions as a meaningful recruitment pathway for trainees seeking mentorship in applied lifestyle medicine. Through SMAs and group culinary medicine classes, Kellyn delivers evidence-based lifestyle education efficiently, enabling simultaneous engagement of multiple patients while fostering the social support essential for sustained behavioral change.

Mary's Center

Mary's Center is a Federally Qualified Health Center operating in Washington, DC, and Maryland. Their "social change model" integrates medical, social and educational services, including the co-location of a public charter school and health center. The public charter school employs a "two-generation approach," simultaneously addressing the educational needs of children and parents to break cycles of poverty and poor health. By partnering with local health departments and community-based organizations, they actively influence practice standards regarding the social drivers of health. A large proportion of Mary's Center staff come from the communities it serves, further strengthening its ability to provide community-responsive care and services.

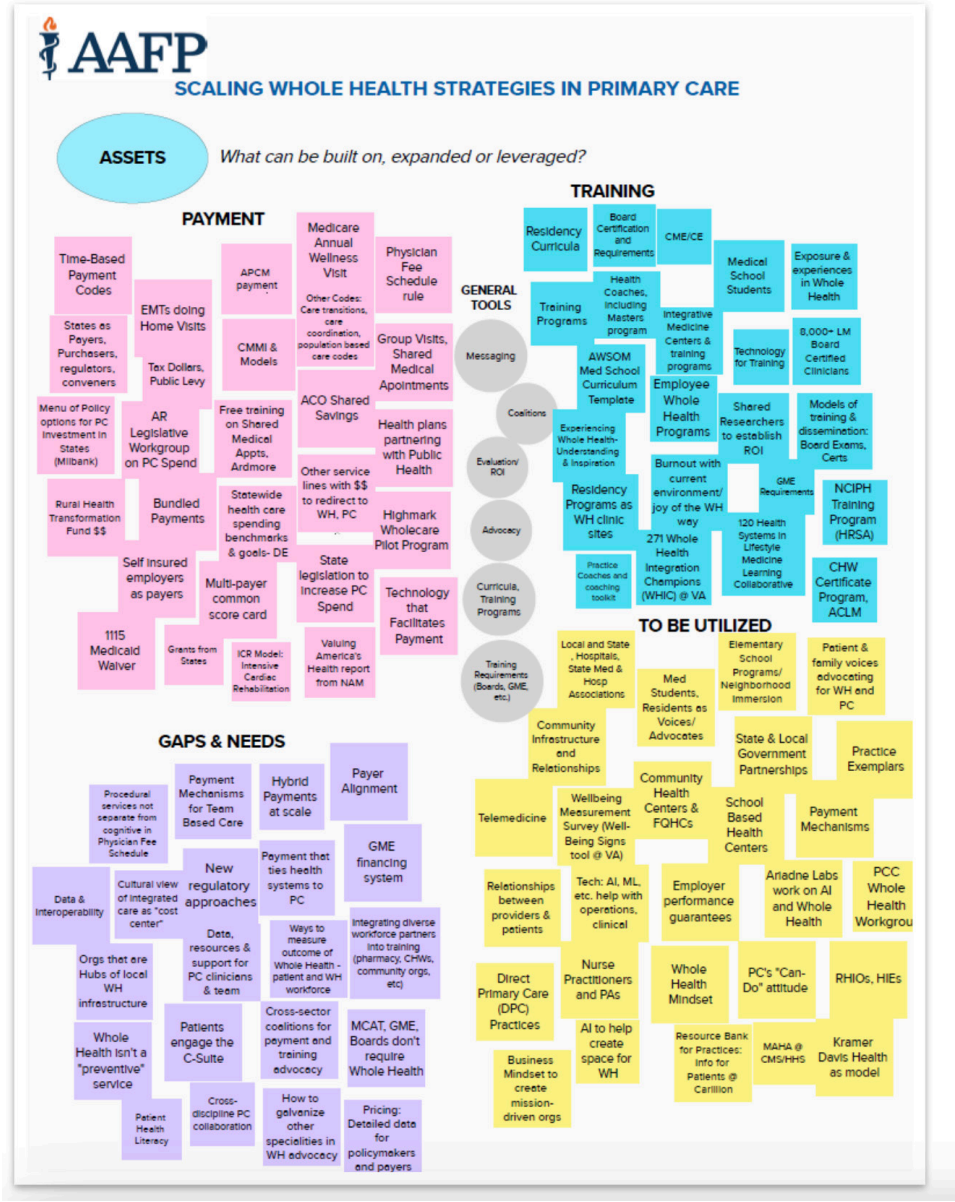
Veteran's Health Administration (VHA)

The VHA is a large, nationally integrated federal system that serves millions of our nation's veterans. It has successfully implemented one of the largest whole health transformations in the country, reaching more than three million veterans and training the majority of its primary care workforce in the model. To scale this culture, the VHA utilizes a streamlined two-hour virtual training course for all primary care and mental health team members. Furthermore, they created a network of more than 520 Whole Health Integration Champions—including physicians and non-physician staff, such as nurses and pharmacists—who are empowered to drive the model locally. This distributed leadership structure not only improves patient engagement but also mitigates staff burnout by fostering a shared sense of mission. The VHA's transformation is anchored in a fundamental cultural shift from asking, "What is the matter with you?" to "What matters to you?" This inquiry centers the entire clinical conversation around the patient's personal mission, aspiration and purpose.

APPENDIX B

Asset map

Summit participants named several existing assets that can support the spread and scale of whole health strategies for training and payment, as well as some broader assets that can be utilized. These assets are captured in the image below.



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