AAFP Whole Health Guide:

PILOT PROJECTS

AAFP

AAFP FOUNDATION

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INTRODUCTION

Family physicians play a critical role in guiding patients toward better health outcomes by addressing not only disease but also the underlying behavioral and lifestyle factors that contribute to overall well-being. Only 16% of health outcomes are attributed to clinical care, 34% result from health behaviors and 47% are attributed to socioeconomic factors, such as where people live, work and play.[1] With chronic conditions like cardiovascular disease, type 2 diabetes and cognitive decline placing an increasing burden on patients and the health care system, family physicians are uniquely positioned to integrate whole health and lifestyle medicine into routine care.

Whole health approaches not only support disease prevention but also empower patients to take an active role in their own health through sustainable lifestyle changes.[2] The AAFP Whole Health: Pilot Projects guide establishes common language and principles to ensure a shared understanding of whole health approaches.

Whole health is a patient-centered approach that considers the physical, mental, emotional and social aspects of health, moving beyond symptom management to promote resilience and long-term wellness. A helpful illustration of the interrelated aspects of whole health is the Circle of Health model. The illustration can be found on page 120 in the National Academies of Sciences, Engineering and Medicine report, *Achieving Whole Health: A New Approach for Veterans and the Nation*.

Whole health aligns closely with lifestyle medicine – an evidence-based field that leverages behavior-based interventions, such as nutrition, physical activity, sleep, stress management and social connection – to prevent, treat and even reverse chronic disease.[3] Improving social resources, such as providing stable housing, access to healthy and nutritious food, reliable transportation and safe environments, will positively impact the overall health outcomes for patients and their communities.[4] Addressing health inequities and disparities in these areas is challenging within communities, requiring multisector collaboration.[5]

Patients are best served when their primary care needs are addressed by a physician-led, integrated care team and feature a trusted relationship with their treating physician. Trusted relationships and open dialogue allow family physicians to align their care with the patient's values and treatment goals. Family physicians can also connect patients with other health professionals and specialists who promote whole health care and wellness to support system-level changes. We encourage you to align clinical practices to whole health approaches with resources in your local communities, along with the best practices and lessons learned from pilot projects you'll read in this guide.

GLOSSARY OF TERMS

Addressing patients' integrated care is a major function of primary care and quality that family physicians are specifically trained and skilled at providing. Integrated care is also a goal among social services, public health, health care professionals, payers and health systems. A shared language aids communication across the sectors. The following definitions can help orient family physicians to the evolving landscape of whole health and integrated care.

Public health is "the science of protecting and improving the health of people and their communities."[6]

Whole health care "addresses the social and structural determinants at the root of poor health, focusing on the priorities and goals of people, families and communities…[and] centers on promoting resilience, preventing disease and restoring health."[7]

Whole health approaches focus on the "physical, behavioral, spiritual and socioeconomic well-being as defined by individuals, families and communities… [and] is an interprofessional, team-based approach anchored in trusted longitudinal relationships to promote resilience, prevent disease and restore health. It aligns with a person's life mission, aspiration and purpose."[2]

Patient-centered care is "integrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences in a system that supports good provider-patient communication and empowers individuals receiving care and providers to make effective care plans together."[8]

Quality health care in family medicine is "the achievement of optimal physical, mental and behavioral health outcomes through accessible, safe, cost-effective, equitable care that is based on best evidence, responsive to the needs and preferences of patients and populations and respectful of patients' families, personal values and beliefs."[9]

Social determinants of health are the "underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age."[10]

Health inequities result from SDOH and their "unequal distribution according to social position… in differences in health status between population groups that are avoidable and unjust."

Health disparities "adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[11]

Health-related social needs result from SDOH and are the unmet "social and economic needs that individuals experience that affect their ability to maintain their health and well-being." They may include "financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care and lack of access to transportation."[12]

Social drivers of health are the "policies, systems and structures that fuel racial inequalities in areas that influence a person's health, such as health care, housing and access to healthy food and transportation."[13]

Lifestyle medicine is a "medical specialty that uses therapeutic lifestyle interventions as a primary modality to treat chronic conditions…applying the six pillars of lifestyle medicine – a whole-food, plant-predominant eating pattern; physical activity; restorative sleep; stress management; avoidance of risky substances; and positive social connections – [and] also provides effective prevention for chronic conditions."[14]

FOUNDATIONAL KNOWLEDGE

Addressing health inequities and disparities within communities is challenging and requires the efforts of multiple sectors and stakeholders. In addition to treatment plans and prescriptions, patients also need access to social services, the internet, employment, housing, transportation and more. Whole health approaches encourage primary care teams to cultivate community relationships and collaborate with public health, social services and other community-based organizations to improve the health of their unique communities.

Lifestyle Medicine

Implementing lifestyle medicine principles within the primary care setting provides a solid foundation for incorporating whole health approaches to patient care. The pillars of lifestyle medicine work in tandem with whole health approaches to support physicians looking to complement treatment-based care and emphasize behavioral and lifestyle factors that impact and improve health outcomes. Lifestyle medicine and whole health apply medical, behavioral and motivational principles to enhance health by understanding that an individual's behaviors are directly influenced and determined by the social, structural and environmental factors around them (i.e., upstream factors).[2] Combining the pillars of lifestyle medicine and the elements of the whole health model ensures that the social and structural determinants of health are also addressed when developing a patient care plan.

Five Elements of Whole Health

Rooted in community support and healing environments, the whole health model utilizes mental and spiritual dimensions to understand patient behavior and what matters to the individual.[2]

Evidence shows that whole health approaches:

- Improve patient care experiences and patient-reported outcomes
- Increase access to care, reduce emergency room use and result in fewer hospitalizations
- Improve clinical quality metrics
- Improve outcomes for specific conditions, such as chronic pain, mental health, traumatic brain injury and aging
- Reduce maternal and infant mortality
- Improve health equity
- Promote team well-being
- Reduce health care expenditures

Research into implementing a whole health model shows evidence for better patient health outcomes, improved patient satisfaction, lower health system and pharmaceutical costs and improved clinician experience.[15]

The whole health model is more than the sum of its parts, consisting of the five elements described below that are interdependent and sometimes overlap.[2]

Element One: People-centered Care

A people-centered care approach focuses on seeing a patient as a whole person – not just their symptoms or illnesses. Whole health considers a person's life experiences and overall situation. It relies on long-term, relationship-based care to build patient and community trust. In family medicine, these lasting relationships help physicians understand their patients better, leading to the best possible care throughout patients' lives.

Element Two: Comprehensive and Holistic Care

Comprehensive and holistic care means looking at all parts of a person's health and working together to find and treat the root causes of illness. This approach brings different health care providers together as a team to give well-rounded care. Comprehensive care is *what care* is provided and includes regular medical treatments, but it assesses important factors like lifestyle, social needs and education. Holistic care describes *how care* is provided and focuses on caring for the whole person, their family and community. Family physicians often lead teams of different health care providers to ensure patients get the best, most appropriate care possible using a multidisciplinary, collaborative approach.[16]

Element Three: Upstream Focused

When a family physician builds a strong, trusted relationship with a patient, they support other important factors that affect health and well-being, such as behavior, social, structural, economic and environmental factors.[7] Physicians who connect and work closely with other specialists and community resources have a better chance of improving these significant health factors that affect individuals and communities. Fixing the deeper causes of poor health requires teamwork and collaboration across different sectors of medicine and communities.

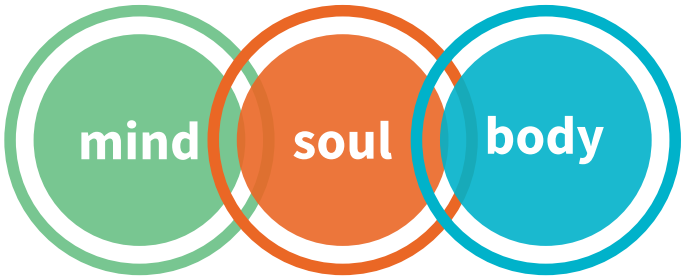
Element Four: Equitable and Accountable

Health equity is a state where "everyone has the fair and just opportunity to be as healthy as possible."[17] Improving the social factors affecting health goes hand in glove with ensuring everyone has fair and accessible health care. Family physicians are well-positioned to address diversity and social challenges that affect patients, families and communities. With whole health, physicians' goals are to create fair and equal health opportunities for everyone. Physicians who follow the whole health model and lifestyle medicine know that many patients struggle to make healthy changes simply because they lack equal access to resources and support.[18]

Health in All Policies improve population health, promote sustainability and advance health equity. Physicians can advocate for environmental, policy and systemic changes in the communities where they live and work and promote equity and accountability for all.[7] Collaboration with community members and advocacy groups allows physicians to offer their unique perspectives and skills to improve community health and wellness.

Element Five: Team Well-being

Team well-being is also a foundational element of any whole health and lifestyle medicine approach, with benefits for the interprofessional team and the patients they are providing care. Team-based care supports the whole care team by alleviating excessive job demands and balancing job responsibilities while promoting a supportive and positive work environment. This helps reduce burnout and promotes wellness, such as mindfulness-based stress training.



AAFP WHOLE HEALTH: PILOT PROJECTS

The AAFP aims to broaden the primary care community's understanding of whole health and lifestyle medicine through the information and lessons learned in the AAFP Whole Health: Pilot Projects guide. Using the six pillars of lifestyle medicine as foundational knowledge for participating physicians, the project identifies programs, strategies and processes that address patients' health-related social needs. The whole health approach empowers patients, families and communities to focus on SDOH, in addition to treating traditional risk factors for chronic diseases, resulting in a holistic strategy.

"The purpose of an interorganizational partnership is not to collaborate because it makes participants' work in health care easier. The purpose is to collaborate because the anticipated outcome connects to a shared goal or objective. Experts in this space acknowledge that efficient and effective collaborations can be challenging to develop, implement and sustain. However, a mutually beneficial partnership is incredibly valuable because it allows groups to achieve more together than one could ever achieve alone."[5]

The goals for the AAFP Whole Health: Pilot Projects are to:

- Leverage existing materials and develop resources to increase awareness and understanding of the whole health approach among AAFP members
- Provide support and technical assistance to a cohort of family medicine practices
- Document lessons learned and disseminate the findings across public health, lifestyle medicine and family medicine audiences

Anticipated outcomes are to:

- Increase the availability and access to technical assistance, products and other resources
- Increase awareness and understanding of whole health concepts among AAFP members
- Increase awareness of findings and tools and strengthen the health care system infrastructure needed to equitably implement whole health approaches into family medicine

Pilot Projects Background

CoxHealth Medical Center – Springfield, MO

Dr. Julia Flax at CoxHealth Medical Center in Springfield, MO, partnered with Ozark Food Harvest and Umoja Food for Health to develop a pilot project that aims to incorporate lifestyle medicine and whole health approaches to individuals with food insecurity by supplying prescription food boxes containing medically tailored groceries to patients with diabetes and/or heart disease.

These medically tailored prescription food boxes contain 14 meals customized by a registered dietician with nutritional guidelines for patients with diabetes and/or heart disease. Contents include shelf-stable groceries, a preloaded debit card, recipes and educational resources on the pillars of lifestyle medicine. Boxes are delivered directly to the patient's home – removing transportation barriers and reducing patients' food insecurity. Preloaded, restricted debit cards were added to the boxes to replace the need to store, package and ship fresh produce to the patient, allowing them to choose their own produce.

Using electronic health records and health-related social needs screening tools allowed Dr. Flax and her team to precisely identify patients with diabetes mellitus and hypertension who experience food insecurity to address the nutrition pillar of lifestyle medicine. The CoxHealth ambulatory care coordinator and nurse care manager provides medical, behavioral and social support services to patients during shared medical appointments and regular check-ins. A Starting the Conversation survey tool is utilized by the ambulatory care coordinator and nurse care manager during these conversations to assess the project's impact.

Spectrum Medical Care Center – Phoenix, AZ

Dr. Jose Rodrigez-Garcia at Spectrum Medical Care Center in Phoenix, AZ, partnered with Chicanos por la Causa and one•n•ten outreach programs to expand on the existing PrEP Mobile U.B.U. Mobile Initiative. The community-based initiative aims to increase access to HIV prevention services and promote holistic health among Latino men who have sex with men and the LGBTQ+ community. Through this pilot project, Dr. Rodriguez-Garcia and his team aim to integrate whole health and lifestyle medicine into sexual health resources to reduce incidents of HIV transmission.

Engagement with the target populations during this project centers around providing comprehensive sexual health services, including education, counseling, condom distribution, pre-exposure prophylaxis and doxycycline for post-exposure prophylaxis. Using the Perceived Stress Scale during a patient's initial encounter with the mobile initiative, this standardized measurement tool allows Dr. Rodriguez-Garcia and his team to track changes in stress levels over time, providing valuable insight into the impact the program is having on patients' well-being. Patients also set a SMART (specific, measurable, achievable, relevant and time-bound) goal to establish and maintain a positive social connection within their community.

During the first encounter with the patient, Dr. Rodriguez-Garcia's team initiates a conversation that extends beyond immediate sexual health needs and begins addressing whole health by exploring stress management and social connection. Lifestyle medicine and whole health concepts are introduced to new patients. Overcoming hesitancy due to a lack of familiarity with lifestyle medicine is a focus of Dr. Rodriguez-Garcia. Through the partnership with Chicanos por la Causa and its network of resources, this project integrates lifestyle medicine concepts by connecting patients with resources for nutrition counseling, stress management, mental health support and social services to provide comprehensive wrap-around care. The seamless connection of patients to essential services and addressing holistic health needs while providing important medical support is at the heart of whole health.

Total Renaissance Wellness – Columbia, MD
Dr. Lindiwe Greenwood at Total Renaissance Wellness in the Columbia, MD, metro area, partnered with HopeWorks of Howard County, Healing House of Columbia and Edesiagurl to provide Whole Person Health and Mind-Body Wellness programs focused on nutrition, stress management, physical movement and social connection for survivors of domestic, intimate and sexual violence.

The target audience of this pilot project is participants of The Survivors Health Project, which is a HopeWorks' program designed to address the long-term effects of sexual and intimate partner violence. The project provides a variety of programs that participants can engage in. Mind-Body Skills programs include Cultivating Resilience, Empowered Healing Through Yoga, a sound bowl healing class, comprehensive Into Balance cooking, nutrition, gardening classes and more. There were also two dedicated social connection events for the participants and the HopeWorks community and staff. These programs are designed to empower survivors by fostering health advocacy and promoting wellness education and practice to build a strong network of supportive and collaborative care.

At the core of this initiative are three fundamental principles: self-care, self-introspection and self-awareness. These principles are essential for survivors to reclaim their agency and rebuild their lives after experiencing violence. By integrating these values into community programming and services, this partnership aims to address the unique needs of survivors while mitigating the environmental, societal and systemic factors that contribute to abuse and neglect.

Through collaborative, community partnerships, this initiative takes a holistic approach to delivering comprehensive, whole health care. Regular and consistent engagement is key, achieved through pre-program workshops, email outreach, weekly meetings, post-group education and social connection events. Communication with participants is further reinforced through HopeWorks' established channels, including newsletters, the organization's website and direct email communication, ensuring sustained engagement and support.

LEARNING MODEL: HEALTH CARE AND COMMUNITY-BASED ORGANIZATION

The Nonprofit Finance Fund, working with the Center for Health Care Strategies, created Resources for Community-Based Organization and Healthcare Partnerships to help community groups and health care organizations work together to improve health. Their model, Integrating to Improve Health: Partnership Models Between Community-Based and Health Care Organizations, organizes collaborations into the following five main areas (with slight adaptions in language for how the pilot projects were organized and for developing future project plans)[19]:

1. Partnership impact – The impact of working together
2. Service model – How services are provided
3. Data sharing – How information is collected and used
4. Patient and community involvement – How decisions are made
5. Financial considerations – How funding and costs are shared

This model helps partners understand how to plan, collaborate and work together. Meeting others where they are is important when family physicians and other health professionals team up with community organizations. Understanding services, funding, data needs and existing partnerships helps align work and strengthen collaborations. Building and maintaining good partnerships can be challenging, but when done well, they make a real difference in people's health. By focusing on upstream factors, such as food, housing and social support, health care becomes more equitable and can improve health for future generations.

The AAFP has developed an addendum to the Nonprofit Finance Fund model at the end of this document as a template for a collaborative project plan. The AAFP Whole Health: Project Plan Template is designed to be replicated by any physician seeking to develop or expand a partnership with a community organization. The addition of partnership impacts to the model will help physicians create a plan for working with and within community groups. It is designed to be used by any physician who wants to start or grow a partnership. While each project may look different depending on location and needs, the plan template provides a starting point. The project plan template focuses on the model's five main (adapted) areas: partnership impact, service model, data sharing, patient and community involvement and financial considerations. Identifying outcome goals for each strategy and listing key activities that meet goals can help physicians organize their approach.

On the next page are examples of the information each participant provided while developing individualized plans for their pilot projects by implementing the model's five areas.

Strategy 1: Partnership Impact – The partnerships enable those involved to achieve more together than they could alone.

CoxHealth Medical Center – Springfield, MO	*Spectrum Medical Care Center – Phoenix, AZ*	*Total Renaissance Wellness – Columbia, MD*
Outcome Goal The partners will develop new ways of working inside and outside the community, strengthening connections among service providers, funders, social service agencies, health systems, academic research centers and government agencies. **Key Activities** • CoxHealth team connects with Ozark Food Harvest and engages with the Umoja Food for Health team to develop a meal kit program to provide Fresh+Pantry prescription food boxes	**Outcome Goal** The partners will leverage and strengthen strategic partnerships to significantly expand the reach and effectiveness of HIV prevention services for underserved populations. **Key Activities** • Strengthen the collaboration with Chicanos por la Causa to enhance outreach to young Latino MSM, LGBTQ+ and immigrant communities • Enhance and expand comprehensive services tailored to the unique needs of transgender and non-binary individuals by leveraging SMCC's established outreach program	**Outcome Goal** The partners will create and establish a collaborative network among key community entities dedicated to serving survivors of domestic, sexual and intimate partner violence. It will focus on building a comprehensive, community-based support system designed to foster resilience and empowerment among survivors. **Key Activities** • Establish a working relationship with the HopeWorks organization • Develop an eight-month whole health program that will service participants, creating a foundational program to provide services and tools to survivors on their recovery journey

Strategy 2: Service Model – The partnerships reflect a primary care service and/or multiple overlapping services.

CoxHealth Medical Center – Springfield, MO	*Spectrum Medical Care Center – Phoenix, AZ*	*Total Renaissance Wellness – Columbia, MD*
Outcome Goal The partners will coordinate the delivery of a complementary set of services for shared clients. The partners actively connect their services, often through roles that strengthen service linkages.	**Outcome Goal** The partners will enhance overall well-being and resilience among patients taking PrEP by implementing a comprehensive whole health approach that addresses stress management and promotes holistic health outcomes.	**Outcome Goal** The partners will implement a comprehensive and integrative whole health program that addresses stress management, nutritional awareness and the benefits of movement and social connection to promote holistic health outcomes and to combat the deleterious effects and sequelae of those affected by and who are survivors of abuse.
Key Activities • Coordinate delivery of a complementary set of services for shared clients, actively connecting their services, often through roles that strengthen linkages • Full SDOH screening using health-related social needs tool by CoxHealth ambulatory care coordinators (conducted annually for patients in the Primary Care Health Home program) to identify patients with food insecurity; patients will be identified on a rolling basis by CoxHealth nurse care managers and behavioral health consultants by asking targeted questions about food insecurity • Screenings will be ongoing, with enrollment in the program occurring on a rolling basis with a capacity of providing 62 patients with prescription food boxes each month • CoxHealth support staff include nurse care managers and ambulatory care coordinators to coordinate with Ozarks Food Harvest to order prescription food boxes, provide outreach to patients about prescription food box availability and pick up, education classes, surveys (including the Starting the Conversation tool), collect stories about the impact of the program and track the number of additional community referrals	**Key Activities** • Assess the effectiveness of our stress management interventions by administering the Perceived Stress Scale during the initial encounter and at each subsequent visit for PrEP; the standardized measurement tool will track changes in stress levels over time, providing valuable insights into the impact of the program on participants' overall well-being • Participants will set a SMART (specific, measurable, achievable, relevant, time-bound) goal focused on establishing and maintaining a positive social connection in their community	**Key Activities** • Use the following survey instruments to assess baseline knowledge, willingness to change and impact of the program on participants: – Perceived Stress Scale – Mind-Body Skills group pre- and post-group evaluation – Whole Person Health physical movement scale – Whole Person Health food assessment • Standardizing the Perceived Stress Scale will allow tracking of changes in stress levels over time; narrative responses will provide insight into the level of awareness and evolution of the participants throughout the program; assessments will be given to new participants at the start and end of the session

Strategy 3: Data Sharing – The partnerships connect data with variations in usage, access, systems and reporting.

CoxHealth Medical Center – Springfield, MO

Outcome Goal

The partners (i.e., CoxHealth and Ozarks Food Harvest) will share de-identified patient-level data with limited access to view full records and/or input data. Both organizations will maintain separate systems to track data and provide regular program updates to each other. The two partners will regularly review program-level and/or outcomes data to inform decision making.

Key Activities

- Share de-identified patient-level data while maintaining separate systems
- Regularly review program-level and/or outcomes data to inform decision making
- Provide regular program updates to each other
- Shared data will include:
  - Number of patients identified meeting criteria for inclusion in the program
  - Number of patients impacted/served; two groups – those with prescription food boxes with lifestyle medicine educational handouts and those with prescription food boxes and who also attended Lifestyle Medicine Shared Medical Appointments
  - Number of patients participating in LSMAs – healthy lifestyle nutrition education
  - Starting the Conversation tool pre- and post-assessment results
  - Survey results about how the program impacted each patient
  - Stories that illustrate the impact of the project and provide a human dimension to the data
  - Tracked biometrics: body mass index, blood pressure and HgbA1c (for patients with diabetes)
  - Number of community referrals: this is currently being done manually and is not able to be automated at this time

Spectrum Medical Care Center – Phoenix, AZ

Outcome Goal

The partners will establish a comprehensive and efficient data-sharing framework to enhance program effectiveness and collaborative outreach efforts.

Key Activities

- Establish a comprehensive data-sharing agreement with SMCC's outreach team to facilitate seamless information exchange to enhance program effectiveness
- Develop and implement a memorandum of understanding with Chicanos por la Causa to formalize our partnership and establish clear guidelines for data sharing, collaborative outreach efforts and mutual support in serving target populations

Total Renaissance Wellness – Columbia, MD

Outcome Goal

The partners will establish open and explorative communication between the community practitioners and HopeWorks.

Key Activities

- Information on the practitioners, programming and participants was shared, analyzed and aggregated to compile the whole health pilot project team document
- Correlate and share lessons learned with HopeWorks to support stress management programming, particularly with at-risk populations

Strategy 4: Patient and Community Engagement – The partnerships may shift depending on the engagement with the target population.

CoxHealth Medical Center – Springfield, MO

Outcome Goal

The partners will identify the target population by identifying social drivers of health causing health inequity by employing SDOH screenings using the health-related social needs tool by CoxHealth ambulatory care coordinators (conducted annually for patients in the Primary Care Health Home program) to identify patients with food insecurity.

Key Activities

- Identify patients on a rolling basis by CoxHealth nurse care managers and behavioral health consultants by asking targeted questions about food insecurity
- Ongoing screenings with enrollment in the program on a rolling basis with a capacity of providing 62 patients with prescription food boxes each month
- CoxHealth support staff: nurse care managers and ambulatory care coordinators will coordinate with Ozarks Food Harvest to order prescription food boxes, provide outreach to patients about prescription food box availability and pick up, education classes and surveys (including the Starting the Conversation tool), collecting stories about the impact of the program and tracking the number of community referrals

Spectrum Medical Care Center – Phoenix, AZ

Outcome Goal

The partners will expand the services of the PrEP U.B.U. Mobile Initiative to target underserved populations. Through culturally sensitive, status-neutral approaches and comprehensive tracking methods, the initiative aims to enhance HIV prevention and reduce health disparities in the community.

Key Activities

- SMCC's outreach team will implement diverse marketing strategies to enhance community engagement and participation in the initiative
- Establish a comprehensive referral system in partnership with one•n•ten – an LGBTQ+ youth organization – to ensure seamless access to additional support services and resources for our target population

Total Renaissance Wellness – Columbia, MD

Outcome Goal

The partners will create a supportive and inclusive environment where individuals can actively participate in their healing and empowerment journey. The pilot project will enable a community-driven support network to engage survivors and develop and deliver services that prioritize the voices, needs and experiences of survivors of domestic, sexual and intimate partner violence.

Key Activities

- HopeWorks and Total Renaissance Wellness will work together to implement community engagement (through social media, email and personal invites) to bring awareness and participation to the initiative
- A kickoff event will introduce the practitioners and their respective programs to the community
- Conduct one-on-one interviews with potential participants (20 minutes each) to understand their motivation, previous community engagements and personal goals
- Ongoing check-in and survey assessments of the pilot project and its effects

Strategy 5: Financial Considerations – The partnerships need to consider financial stability and sustainability.		
An itemized budget template for partners to maintain details of the projected and actual costs of items for the project		
Personnel		
[name of individual]	[percentage of time spent on project]	[total personnel cost]
Community Partner/Consultants/External Partners		
[name of individual and/or associated organization]	[percentage of time spent on project]	[total partner cost]
Supplies/Materials Costs		
[name of material]	[name of partner utilizing material]	[total cost for material]
Travel		
[personnel traveling]	[total cost of travel]	[total cost of lodging/meals]
Other Expenses		
[expense]		[total cost of expense]
Total		**$**

LESSONS LEARNED DURING THE PILOT PROJECTS

At the time of publication of this guide, the project participants were operating in the final phase of their pilot projects. Throughout this project, Drs. Flax, Rodriguez-Garcia and Greenwood have established effective relationships with their respective community partners and created solid foundational programs that integrate the pillars of lifestyle medicine and whole health to promote wellness for their target populations. During their projects, each physician kept notes of successes and challenges, which are summarized below.

CoxHealth Medical Center – Springfield, MO

Project Successes

- The partners successfully provided prescription food boxes to 48 patients in February 2025, with plans to continue this support for four months.
- The strong collaboration among CoxHealth, Ozark Food Harvest and Umoja Food for Health, as well as the direct shipping model for sending prescription food boxes containing medically tailored groceries and a produce prescription, have all contributed to the project's success.
  - The direct shipping model has ensured that patients receive prescription food boxes without transportation barriers, further supporting their health and autonomy.
- The comprehensive approach to addressing food insecurity and integrating lifestyle medicine has been crucial in achieving positive outcomes.
- Of the 68 patients meeting the criteria to participate in the program, 45 have enrolled, leading to a 66.2% engagement rate.
- Patient feedback has been overwhelmingly positive, with some hailing the positive impact the project has had on supporting those with limited financial and transportation resources to purchase groceries.
- The ambulatory care coordinators connected a few patients with Community Fridges in Springfield, where they can receive fresh produce year-round at no cost. The knowledge of other resources available locally to assist with healthy food options for those individuals with food insecurity has been very beneficial, integrating the nutrition pillar of lifestyle medicine.

Project Challenges

- Given the transportation and logistical issues, the primary challenge was ensuring patients could access the food boxes. Additionally, coordinating the integration of lifestyle medicine and addressing SDOH required careful planning and collaboration.
  - The partners shipped food boxes directly to patients' homes to address this challenge, eliminating transportation barriers.

  - The coordination enhanced patient accessibility, allowing for better integration of lifestyle medicine and addressing the SDOH by providing consistent access to nutritious food and educational materials to patients' homes.
- It was debated whether or not to include fresh produce in the boxes, as including it would require refrigeration and regular checks to ensure no expiration.
  - Ultimately, the decision was made to provide shelf-stable groceries and include produce prescription debit cards for the patients to purchase their choices of fresh produce.
- Considerable time was needed to sign the business associate agreement with the partner and have it approved by the legal department. This slight delay impacted timelines and required an adjustment to the initial implementation schedule.
- Contacting the identified patients via telephone was another challenge.
  - Some patients perhaps don't have minutes on their phones, or their voicemails are full, so connecting was a challenge. The patients who called back were included to receive the remaining months of food boxes while we had slots available. Several patients were initially identified to qualify for the project, but we have not been able to contact them.

Spectrum Medical Care Center – Phoenix, AZ

Project Successes

- Significant successes have been made in developing and expanding the community partnership, improving patient outcomes, particularly in PrEP access and retention.
- Other successes have been made in implementing the pilot project with Chicanos por la Causa, demonstrating a positive impact on the project's approach to whole health and lifestyle medicine. A key achievement has been developing and implementing a comprehensive tracking system for Chicanos por la Causa patients enrolled in lab assistance programs. A data sheet includes vital information, such as enrollment status, program details and renewal dates.
  - By ensuring patients maintain their enrollment in the lab assistance program, we have minimized disruptions in accessing essential diagnostic testing and treatment. This continuity of care is crucial for managing chronic conditions and preventing health complications, directly contributing to improved physical health outcomes.
- Despite the technical challenges related to system integration, notable successes have been achieved in developing and implementing aspects of the data-sharing plan with Chicanos por la Causa. A significant accomplishment has been establishing a process for sharing essential patient information without requiring duplicate data collection. This avoids redundant efforts and streamlines workflows for both partner organizations.
  - Regular communication channels have been established to discuss data-sharing needs, identify key data points and develop efficient processes.
- A foundation of mutual understanding and trust between organizations has facilitated open communication and a willingness to work together to overcome challenges.
- A key achievement has been implementing the Perceived Stress Scale tool. It has been valuable in identifying patients' stress levels and the specific factors contributing to their stress.

Project Challenges

- While the partners are committed to addressing SDOH, they may prioritize different areas of treatment and services based on their respective missions, expertise and the specific needs of the populations they serve. This can sometimes lead to a lack of alignment in goals and strategies, making it challenging to develop a truly integrated program.

  - Efforts have been made to prioritize collaborative goal setting with partners to address the challenge of varying SDOH focuses. Engaging in open discussions to identify shared priorities related to SDOH and lifestyle medicine has helped. Working together to define common goals ensures efforts are aligned and mutually reinforced.
- The memorandum of understanding process has been more protracted than anticipated, requiring ongoing revisions and input from both legal teams. This extended timeline has presented some limitations, as certain aspects of the joint-service model, particularly those involving data sharing and integrated service delivery, are contingent upon the finalization of the MOU.
  - Until the MOU is finalized, the ability to share patient information is limited, which hinders our capacity to fully integrate services and personalize care plans.
  - Conflicting medical record systems hinder direct integration among partners. The lack of interoperability poses a significant hurdle to seamless data exchange and necessitates alternative approaches.
- Other challenges include issues connecting with the target population and having many patients unfamiliar with lifestyle medicine concepts. Often, they don't readily grasp the connection between their sexual health and the broader pillars of lifestyle medicine, such as nutrition, exercise, stress management and sleep. This lack of understanding can hinder patient engagement, as they may not fully appreciate the benefits of a whole health approach.

Total Renaissance Wellness – Columbia, MD

Project Successes

- The marketing and flexibility of the program have been key successes of the project.
- Regular touch points and syncing with the partners established a strong rapport and desire to make the program successful.
- Connecting shared resources among partners has successfully addressed technological and transportation barriers for participants.
- There has been overwhelming positive feedback on the Cultivating Resilience program. Participants have asked for a repeat program and have said the program has already changed their lives.
  - This program meets the basic tenets of lifestyle medicine by educating and sharing information with participants without worrying about cost and/or access issues.
- One of the most profound successes is the change and decrease in obsessive and trauma-based reactions in all of the program participants. Partners have witnessed newfound strength and confidence in participants regarding their mental health, nutrition and resilience.

Project Challenges

- Dr. Lindiwe is the project's principal investigator and the only internal staff. Though there is support from community organization partners, more administrative and logistical tasks require additional management to meet the project's goals.
- Some technology and transportation concerns were challenging for those in the survivorship program who seek to engage in the Mind-Body Wellness program. They may lack the necessary means to access it.
- Funding for scalability and future program plans have required additional planning, as no larger medical institution backs the project. An independent physician organization is running the program.

ADDITIONAL TOOLS AND RESOURCES

As we have seen throughout the pilot project descriptions, successes and challenges, collaboration is a key element of public health. Still, it is not always straightforward and easy to accomplish. It requires time and careful consideration with many stakeholders on the same page to ensure initiatives and efforts are organized for success and long-term support.

Many organizations have created valuable resources and tools outlining their efforts to make collaboration successful. Their efforts have been documented and may provide useful information for others seeking to expand their understanding and knowledge of community collaboration and implementation. Below are resources and tools which may aid you in collaborating with other organizations.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Case Studies

Case Studies in Innovative Community Engagement to Improve Health Equity in Cardiovascular Disease

Journal Article

How to Use (and Not Use) New Code G0136 for SDOH

On-demand CME Opportunities:

- Health Equity for EveryONE: Comprehensive
- Health Equity
- Lifestyle Medicine in Practice
- Value-based Care and Payment

Position Paper

Integration of Primary Care and Public Health

Research Projects

Community Engaged Lifestyle Medicine

Previous work sponsored by the Ardmore Health Institute included community engaged lifestyle medicine pilot projects aimed at incorporating traditional health care and health care settings with community outreach on the following topics:

- Diabetes Undone: Lifestyle Medicine and the Management of Diabetes
- Diets Don't Work: Real Food for Better Health
- Interrupting Teen Suicide at the Gates of Primary Care

Teaming Up with Public Health

- Community Collaboration Guide
- Extending the Family Physician's Impact From Clinic to Community
- The Family Physician Public Health Partnership Guide

The EveryONE Project

Community Collaboration

AMERICAN COLLEGE OF LIFESTYLE MEDICINE

- Delivering High-Value, Whole-Person Care in Current Payment Models
- Lifestyle Medicine Patient Handouts
- Lifestyle Medicine Reimbursement Resources and Shared Medical Appointments Toolkit

BLUE CROSS BLUE SHIELD

Health Equity News Articles

COMMUNITY PREVENTIVE SERVICES TASK FORCE

The Community Guide is a collection of evidence-based recommendations and findings from the Community Preventive Services Task Force. The CPSTF makes evidence-based recommendations about the effectiveness and economic impact of public health programs, services and other interventions used in real-world settings.

HEALING WORKS FOUNDATION

Using the Personal Health Inventory With Your Patients can help the patient and physician understand more about their mental, emotional, physical and spiritual health and how all those aspects interact.

- Personal Health Inventory for Primary Care
- Personal Health Inventory
- Whole Person Primary Care

The HOPE Note is a tool to elicit the information a physician needs from a patient to better understand their issues beyond the regular medical visit.

- The HOPE Note Guide with Social Determinants
- The HOPE Note Template

NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE

The Achieving Whole Health: A New Approach for Veterans and the Nation report includes examples of whole health in practice, implementing and engaging the five elements of whole health in various settings. The Veterans Health Administration's whole health system illustrates the shift away from medical- and disease-focused health care approaches to a focus on health promotion and disease prevention with aims to improve health, wellness and the lives of veterans who served.

Mary's Center

Mary's Center is a federally qualified health center that provides comprehensive physician and behavioral health care integrated with social services and family literacy programs to people in the Washington, D.C., area. Mary's Center provides culturally and linguistically appropriate services and strives to have its participants actively engaged in their care. In addition to ensuring services are deliberately designed with equitability and accountability, Mary's Center works to ensure the well-being of its team members.

National Intrepid Center of Excellence

The National Intrepid Center of Excellence operates through a whole health lens to support veterans coping with post-concussive symptoms, depression and post-traumatic stress disorder. NICoE provides short-term interventions through a holistic and comprehensive approach to the needs of each participant. The program empowers participants to take ownership of their health to support long-term well-being as each participant continues their individual journey to complete the NICoE program.

Program for All-inclusive Care of the Elderly
The Program for All-Inclusive Care for the Elderly was developed by Lok, a community-based organization in San Francisco, as an alternative to nursing home care in 1972 to extend participant independence in the community and enhance quality of life and well-being. PACE provides the elderly community with medical care, social services and maintenance rehabilitation services. PACE is a federally authorized Medicare/Medicaid managed-care benefit for individuals over 55 years who the state certifies as eligible for nursing home care but who want to stay in their communities. Different systems in the United States implement the concept.

Southcentral Foundation/The Nuka system of care
Southcentral Foundation is an Alaska Native-owned, nonprofit health care organization that serves 65,000 Alaska Native and American Indian people. This integrated and comprehensive system offers patients a full range of health care services, including services that address many SDOH and are designed to create healthy and thriving communities rooted in Native Alaska culture and practices.

NEMOURS CHILDREN'S HEALTH

The Moving Health Care Upstream Health Care & Community Partnerships and supporting resources were designed with the idea that new approaches are needed to address persistent and costly health inequities. Improving health and well-being for patients and entire communities requires strategic layering of upstream, midstream and downstream tactics.

NONPROFIT FINANCE FUND: FUNDAMENTALS FOR NONPROFITS

Resources for Community-Based Organization and Healthcare Partnerships are practical resources to help emerging and existing partnerships address common barriers and strengthen collaborative activities.

TEAGLE FOUNDATION

People, Tools, and Processes That Build Collaborative Capacity employs the work of Arthur Himmelman's Collaboration Continuum to build on the concept that collaboration helps partners achieve what cannot be done alone. The point of collaboration is to join forces because the anticipated result relates to the shared purpose and goals of the participants.

TED TALK/TEDx

- TEDx – Dr. Meagan Grega: Why Lifestyle Is the BEST Medicine
- TEDx – Robert Waldinger: What Makes a Good Life? Lessons From the Longest Study on Happiness
- TED Talk – Dr. Param Dedhia: Sleep: The Secret to Living the Best 1/3 of Your Life!
- TED Talk – Dr. Judson Brewer: A Simple Way to Break a Bad Habit
- TEDx – Dr. Yami Cazorla Lancaster: Chicken to Chickpeas: A 30-Day Experiment Changed My Life
- TED Talk – Dr. Wendy Suzuki: The Brain-Changing Benefits of Exercise
- TEDx – Dr. Jay Winner: The Under-Recognized Foundation for a Healthy Life
- TEDx – Dr. Dean Ornish: 7 Billion Well

THE PRACTICAL PLAYBOOK

- The Practical Playbook: Public Health and Primary Care Together
- The Practical Playbook II: Building Multisector Partnerships That Work

UNIVERSITY OF KANSAS

Community Toolbox was designed to help individuals take action, teach and train others in organizing for community development. These resources help assess community needs and resources, address SDOH, engage stakeholders, create action plans, build leadership, improve cultural competency, plan evaluations and sustain efforts over time.

AAFP WHOLE HEALTH: PROJECT PLAN TEMPLATE

Below is a template to assist you in developing, planning and implementing a whole health project plan.

Name: _____

Credentials: _____

Practice Name: _____

Location: _____

Project Plan Summary (high-level narrative of the project plan): _____

Target Population: [Describe the population, health-related social needs of the population, barriers to achieving optimal health and upstream social, structural/systemic and environmental factors.]
Patient Engagement: [Describe how you engage with the targeted population for the project plan. Provide examples of how engagement can be tracked: 1) surveys asking how the program impacted participants; 2) details about the outreach strategy – how the program connected with the patient population; 3) track the number of participants involved, etc.]
Lifestyle Medicine Pillar(s): [Describe the pillar(s) of lifestyle medicine that will be the highest priority to address among the targeted population. Describe how the pillar(s) impact(s) the targeted population.]
Community Partner(s): [Provide the name, location and function that partner(s) provide(s) to your community. Is this a new or existing partnership? If it is an existing partnership, provide background on the partnership relationship. Describe how your community partner(s) serve(s) the targeted population (e.g., what services does the community partner provide, and how does that complement your efforts to reach and impact the targeted population?) Provide details on how you will collaborate with community partner(s). Consider how to establish a relationship to promote a reliable partnership, including how to meet the partner where they are.]

Strategies: Utilizing the five partnership model strategies below, set at least one goal for strategies 1-4 and develop a budget for strategy 5.

Strategy 1: Partnership Impact – The partnerships enable those involved to achieve more together than they could alone.

Outcome Goal: [Detail at least one goal for your project plan to meet the Partnership Impact strategy.]

Key Activities: [What specific actions, tasks and/or deliverable(s) will you initiate to meet the outcome goal for this strategy?]	**Start Date:** [When do you plan to develop and implement this key activity?]	**End Date:** [When do you plan to complete implementing this key activity?]	**Team Member(s) Responsible:** [Who will implement this key activity?]

Strategy 2: Service Model – The partnerships reflect a primary care service and/or multiple overlapping services.

Outcome Goal: [Detail at least one goal for your project plan that will meet the Service Model strategy (e.g., SDOH screening tool protocol, SDOH billing and coding, team-based care, service models/referral, service/pathway, staff training (e.g., cultural competency, anti-racism, etc.)).]

Key Activities: [What specific actions, tasks and/or deliverable(s) will you initiate to meet the outcome goal for this strategy?]	**Start Date:** [When do you plan to develop and implement this key activity?]	**End Date:** [When do you plan to complete implementing this key activity?]	**Team Member(s) Responsible:** [Who will implement this key activity?]

Strategy 3: Data Sharing – The partnerships connect data with variation in usage, access, systems and reporting.

Outcome Goal: [Detail at least one goal for your project plan that will meet the Data Sharing strategy. Consider data availability, alignment of technology platform(s), development of data-sharing agreements, community health information exchanges, etc.]

Key Activities: [What specific actions, tasks and/or deliverable(s) will you initiate to meet the outcome goal for this strategy?]	**Start Date:** [When do you plan to develop and implement this key activity?]	**End Date:** [When do you plan to complete implementing this key activity?]	**Team Member(s) Responsible:** [Who will implement this key activity?]

Strategy 4: Patient and Community Engagement – The partnerships may shift depending on the engagement with the target population.

Outcome Goal: [Detail at least one goal for your project plan that will meet the Patient and Community Engagement strategy. How will you engage/reach your target population? Consider the barriers to implementation, gathering community input, achieving health equity, etc.]

Key Activities: [What specific actions, tasks and/or deliverable(s) will you initiate to meet the outcome goal for this strategy?]	**Start Date:** [When do you plan to develop and implement this key activity?]	**End Date:** [When do you plan to complete implementing this key activity?]	**Team Member(s) Responsible:** [Who will implement this key activity?]

Strategy 5: Financial Considerations – The partnerships need to consider financial stability and sustainability.

This table is an example template of an itemized budget. To better understand the effectiveness of the awarded funds, please fill out and maintain a budget detailing the projected and actual costs of project details, such as the number and cost of employing staff, cost of travel, cost of resources, etc. Please adjust this template or utilize another budget tool that best fits your needs.

Personnel		
[name of individual]	[percentage of time spent on project]	[total personnel cost]
Community Partner/Consultants/External Partners		
[name of individual and/or associated organization]	[percentage of time spent on project]	[total partner cost]
Supplies/Materials Costs		
[name of material]	[name of partner utilizing material]	[total cost for material]
Travel		
[personnel traveling]	[total cost of travel]	[total cost of lodging/meals]
Other Expenses		
[expense]		[total cost of expense]
Total		**$**

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