

Implementing and Spreading Whole Person Care: Report of a Summit

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Introduction

How can Whole Person Care be made available to every person, every time, without the need for heroic measures from clinical teams?

Currently, despite high spending, the US healthcare system does not produce good outcomes for patients with chronic illness, fails to prevent chronic illness before it develops, is a source of widespread dissatisfaction among patients and clinical teams, and suffers from deep inequities.

The reasons for this mismatch between performance and spending have been enumerated: with a general focus on illness rather than health, the US healthcare system is biased toward more expensive and profitable acute care, procedures, and pharmacological management of chronic disease (rather than prevention and self-management strategies) and underinvests in primary care as the foundation of a well-functioning healthcare system.¹⁻⁴ Healthcare practices, systems, and leaders are often held more accountable for financial goals than health goals, with wide-ranging downstream effects on practice. In the evolution of electronic health records (EHRs) from billing platform to patient health record, for example, less attention has been paid to user experience, public health, preventive care capabilities, and healthcare improvement than to coding and billing documentation. Similarly, measurement systems developed for payment, accountability, and healthcare improvement most often reflect treatment or prevention of specific diseases and rarely capture meaningful patient experiences and health goals.

The result is that clinical teams are asked to focus on narrow disease-based goals, patient throughput, and processes of care and are not supported in efforts to focus on individual health goals, self-efficacy, and improvement in the health of the communities they serve.

Thus, the current system of healthcare in the US fails to meet the needs of those it is intended to serve and those who work in it. Patients feel at the mercy of a system that is not designed for them as individuals, that treats symptoms rather than causes, and that manages disease rather than promoting health and well-being. Clinicians feel rushed, managed, and bound by measures and payment structures that do not value the work they put into building meaningful therapeutic relationships and community connection. The growth of concierge medicine,⁵ the strong and durable interest in complementary and integrative health (CIH) and lifestyle medicine,⁶ as well as the over two trillion dollars spent for “wellness” products and services⁷ are examples of the many indicators that patients need more from the current public and insurance funded healthcare system than they currently receive.

Whole Person Care (also known as Whole Health) provides a fundamentally reorienting perspective on our current system of care: prioritizing wellness while treating illness; focusing on the individual and their meaning, purpose, and goals for health while working toward the health of communities and populations;

and creating a healthcare system designed to care about the individual, their family and community, and the health of the nation as a whole. Systems that have successfully implemented Whole Person Care² as well as other scaled improvements in the healthcare system suggest a path to Whole Person Care for the healthcare system as a whole, anchored by high-quality primary care.¹

There have been many attempts to reform the US healthcare system over the years; these efforts have most often focused on improving efficiency, clinical quality, and safety and on models of payment that incentivize the “right care delivery” for established disease. Delivering Whole Person Care to every patient, every time, everywhere will require a reorientation of the health reform agenda to focus on the interests, care preferences, and needs of those the systems of care are intended to serve and those who deliver that care. This report aims to contribute to that shift with an overview for decisionmakers and stakeholders at all levels of the system of the changes necessary to see Whole Person Care become routine and regular.

About the Summit and Report

This report is the result of a Whole Person Care Summit organized by and held at Ariadne Labs in Somerville, Massachusetts on May 19, 2026, funded by the Healing Works Foundation. The fourteen attendees included individuals of varied backgrounds, bringing to the table perspectives from clinical practice, research, and policymaking in primary care and Whole Person Care (Appendix A). The day-long discussion (Appendix B) built on a synthesis of extensive evidence around Whole Person Care, including two landmark National Academies of Science, Engineering, and Medicine (NASEM) reports.^{1,2} It addressed the principles of Whole Person Care, how to operationalize Whole Person Care in clinical practice, and the scaffolding necessary to implement and spread Whole Person Care in the US.

While this report is deeply researched and the discussion it summarizes was rich in ideas and details, it is not the result of a comprehensive or systematic review. The ideas described here should be read as indicators and examples that provide direction for future exploration, specifically for a comprehensive survey of Whole Person Care and the detailed requirements necessary for its implementation at scale.

An Emerging Consensus: Whole Person Care

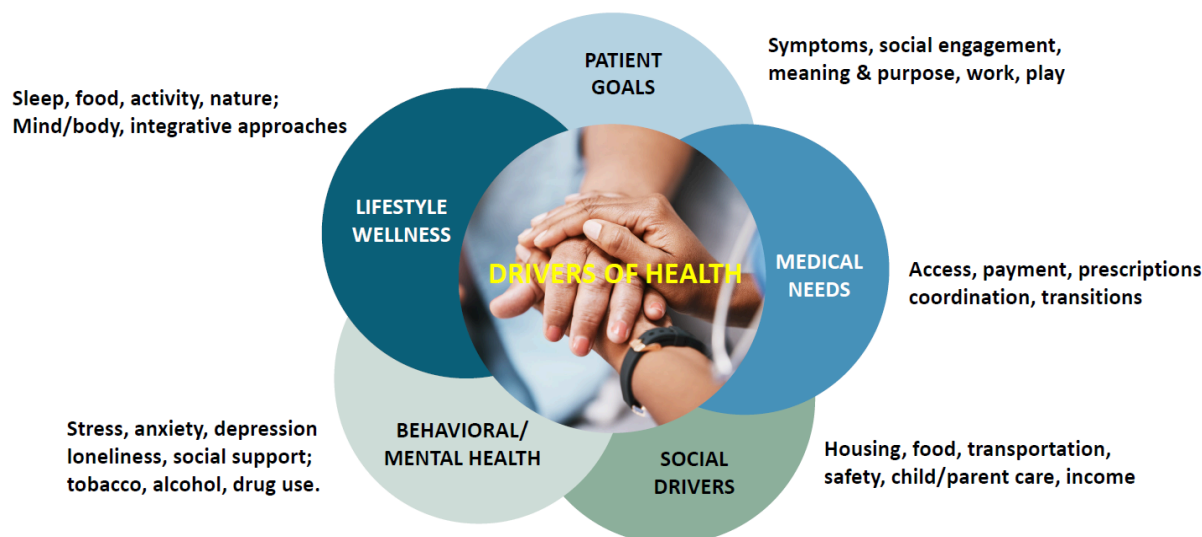
Over the last 5 years, a consensus^{2,8} has emerged that improving prevention, care, and health outcomes for patients with chronic illness will require the implementation and spread of Whole Person Care. There is no single prevailing definition of Whole Person Care; however, five principles appear to characterize the delivery of this type of care:

1. **Meaning and Purpose:** Whole Person Care is centered around a person’s goals and purpose; health and healthcare are in service of a person’s life aims.

2. **Trusting Relationships:** Whole Person Care is anchored in relational care and psychological safety. In practical terms, this principle requires a balance of timely access to care and continuity of relationship with clinical teams.
3. **Comprehensive and Holistic:** Whole Person Care considers a person's entire life and context—mind, body, social, and spiritual dimensions, not just their diseases—and recognizes the root causes of ill-health and healing at both individual and community levels.
4. **Accountability and Accompaniment:** Whole Person Care seeks the health and flourishing of people, families, communities, and populations, taking responsibility for health outcomes and accompanying them on their journey toward their health goals.
5. **Interprofessional Teams and Coordinated Care:** Whole Person Care is characterized by high-functioning interprofessional and intersectoral teams, teamwork, and coordination, integrating care for the individual across systems and sectors that allow each patient to get the support they need to address their individual drivers of health.

Together, these principles describe a type of care that centers the full person in the midst of their community. To succeed, Whole Person Care must deeply understand a person's and a community's context, including drivers of health (Figure 1). Context comprises any and all drivers of health that are relevant to the person or community in question. It is a multi-level and dynamic concept: the various components of a person's or community's context are interrelated and evolve over time.

Figure 1: Drivers of Health



*This figure lists the primary drivers of health that most patients need to improve their health and wellbeing and get the medical treatment services they need for chronic conditions. Whole person care derives from clinical processes that determine which of these drivers are important at any one time for a person and then organizes its services to support a person in achieving their goals. **Source:** Healing Works Foundation*

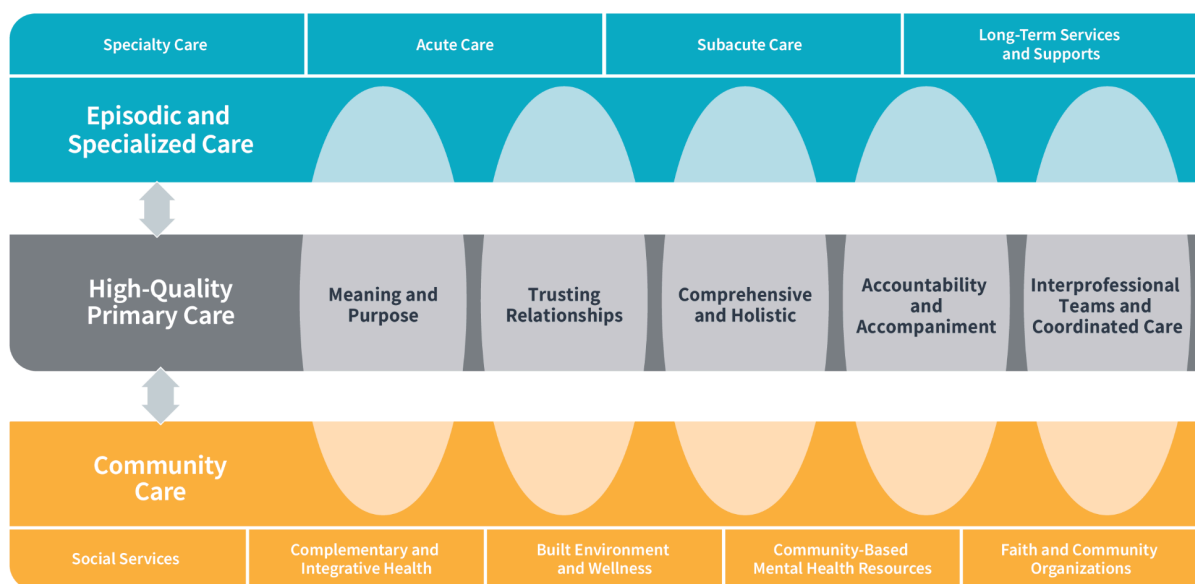
A Fundamental Reorientation of the Healthcare System Using Existing Elements

While there is an emerging consensus on the principles of Whole Person Care drawn from numerous examples, what it looks like when a person meets Whole Person Care and an implementation pathway for widespread adoption of it have not yet been systematically described. Importantly, implementation of Whole Person Care will not require a whole-cloth reinvention of the US healthcare system. The foundational elements of Whole Person Care are known and available in the clinical setting or in the community; the task at hand is to organize and use those elements to produce Whole Person Care.

The Settings of Whole Person Care

Whole Person Care is delivered through three settings: 1) primary care, 2) episodic and specialized care, and 3) community-based services and institutions (Figure 2).

Figure 2: Existing Healthcare Settings and Whole Person Care Principles



According to a 2021 NASEM report,¹ high-quality primary care provides “whole-person, integrated, accessible, and equitable health care” using “interprofessional teams that 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.” As envisioned in this NASEM report, high-quality primary care is the central delivery system for Whole Person Care. Primary care is the foundation of a well-functioning healthcare system and, when resourced adequately and oriented toward Whole Person

Care, plays an essential role as an initial point of access to care, in coordinating and integrating care, and in orienting health care toward the pursuit of wellness rather than simply the treatment of disease.

Acute and subacute care, while generally organized around treatment of or recovery from an acute episode of illness, can and should still be informed by the health goals of the individual and oriented toward helping them achieve what they need for optimal health. The integration of palliative care approaches into acute curative care and the use of pulmonary, cardiac, and stroke rehabilitation services are examples of Whole Person Care operating in acute and subacute settings. While specialty care is generally focused on management or mitigation of disease, many examples exist of specialty care oriented toward achieving wellness as well as treating illness. Specific use cases include a neurology focus on brain health, preventive cardiology, and pain management programs, sports medicine, and a focus on patient activation and preparation for elective joint replacement in orthopedic care. Long-term services and supports (LTSS), including both facility-based and home- and community-based services, when optimally provided through person-centered planning, enable individuals to receive the support they need to live and flourish in the least restrictive environment possible.

Many (but not all) of the services and institutions integral to Whole Person Care operate independent of the healthcare system (Figure 3). People often (though not exclusively) access these community-based services and institutions on their own initiative. Community-based organizations provide the **social services** critical to accessing personal care, housing, food, and transportation that help to address social and structural drivers of health. Public, private, and non-profit resources such as YMCAs, fitness centers, parks, playgrounds, schools, and public transportation play an essential role as the **built environment for wellness**, supporting the behaviors and activities that can prevent or mitigate chronic illness. There are **complementary and integrative health**² services; approaches to health and healthcare, including the rapidly evolving field of lifestyle medicine⁹, that are sometimes integrated into the formal, insurance-based healthcare system but commonly operate alongside it.

Community-based mental health resources, including non-profit mental health agencies and community mental health centers and privately delivered mental health and counseling providers, are embedded in the communities they serve. These distinct elements of the care delivery ecosystem, based in the community, have varied relationships to primary care and to episodic and specialized care. In some cases, they require formal referral from those systems and participate in public and private insurance reimbursement. In other cases, they are paid for through social service and social welfare budgets, civic budgets, and private pay, operating fully independently of the insurance-based health system. Often, they depend on multiple sources of funding.

High-quality primary care plays an important role as a connector between the person, and the care available in the community, and this function is greatly facilitated by smooth bi-directional communication, if not fuller integration.

In addition to these four elements of care that may interact with primary care to a greater or lesser degree, there are a host of institutions, organizations, and other groups that support meaning and purpose in people's lives, including spiritual or religious communities, athletic teams, clubs, and an almost infinite number of other social gatherings. These **faith and community organizations** are fully independent of primary care and the formal health care system, but they are essential to Whole Person Care. They are the structures through which people pursue meaning and purpose in their lives and access what they need to flourish, and they are recognized by high-quality primary care as an integral part of Whole Person Care.

Figure 3: Resources and Services in the Community

Social Services	Supporting the management of social and structural drivers of health (e.g., <i>Food Pantries, Housing Programs</i>)
Built Environment and Wellness	Supporting a healthy lifestyle (e.g., <i>Walkways, Green Spaces, Playgrounds, Hiking and Biking trails, Public Transportation, Wellness Organizations</i>)
Complementary and Integrative Health	Health and healthcare services that commonly operate alongside the formal healthcare system (e.g., <i>CIH Providers, Healthy Lifestyle Providers</i>)
Community-Based Mental Health Resources	Addressing mental and behavioral health and addiction (e.g., <i>Non-profit Mental Health Agencies and private practice therapists</i>)
Faith and Community Organizations	Supporting meaning, purpose, and community in people's lives (e.g., <i>Spiritual or Religious Institutions, Volunteer Opportunities, Hobby-Based Groups</i>)

The care, services, and connection provided through primary care, episodic and specialized care, and the community can be understood as the structural elements of Whole Person Care. But the structures alone don't ensure the delivery of Whole Person Care: the ways in which they function and interact with each other to foster health, well-being, and human flourishing is what makes Whole Person Care a reality.

Processes: Whole Person Care Practices and Approaches

If the settings through which Whole Person Care is delivered are the structures of Whole Person Care, then specific practices and approaches are the processes through which Whole Person Care operates. Some practices and approaches are widespread (such as handoffs and huddles), but others are found almost exclusively in existing Whole Person Care programs (such as explicitly eliciting patients' stories). Very few of them reach every person, every time, everywhere. Below, these practices and approaches are organized according to the principles of Whole Person Care to demonstrate their ability to reorient the care delivered by the US system.

Meaning and Purpose

The first principle of Whole Person Care promotes well-being and supports health creation (salutogenesis), tying health and wellness to purpose and meaning. Understanding what wellness and health means to the person, what the person sees as their health goals, and where the person finds sources of meaning in life allows care teams to guide care according to what matters to each individual.

Most people experience a very personal understanding of their meaning and purpose, understood through their stories and through expressions of priorities, aspirations, and connection to communities or belief systems larger than themselves. Providers of Whole Person Care, when supported by the systems in which they work, can take the time to elicit these stories, understand the underlying meanings, and help people make care decisions based on those meanings. There are skills that can be taught and care processes that can be integrated to elicit, appreciate, and act on what is learned through these stories and expressions.

Even in the current time-constrained and pressured environment of U.S. health care, some clinicians and care teams use this principle, deploying the practices and approaches that embody it in their work (Figure 4). For instance, the National Intrepid Center of Excellence (NICoE) provides diagnosis, clinical care, education, and research for active-duty service members with traumatic brain injury and/or mental health issues that cannot be managed by their own clinicians. At the beginning of any intensive outpatient program at NICoE, each patient tells their story at an intake appointment with the entire interprofessional team to ensure all clinicians have the information necessary to treat the patient without the patient needing to repeat the same information in different settings. The patient and family members remain a part of the interprofessional team throughout the four-week process to develop a treatment plan. Thus, the patient's story remains at the center of the team's work.²

Figure 4: Strategies for Eliciting and Understanding Patient Stories

- Use structured assessments to elicit patient stories (e.g. HOPE Note/PHI, NIH Whole Person Health Index)
- Use electronic screening or AI technology to summarize patient stories
- Have patients write down their stories in their own words
- Have non-PCP team members such as community or social workers elicit stories
- Use storytelling tools, videos, other patients' stories, and the clinician's own journey to motivate patients and help them tell their own stories
- Ask open-ended questions; then be quiet and listen
- See eliciting stories as an ongoing process over multiple visits
- Utilize different "ways in" to a patient's story (e.g. What is important right now? What is on your phone background and why? How would your wife/friend tell your story? What brings you joy?)

Trusting Relationships

Closely related to the first principle, the second principle of Whole Person Care incorporates relational care and the psychological safety it enables. Pragmatically, this principle requires access to care and attention to continuity of relationships. **Without access there is no relationship; care teams must be available to people in a timely fashion.** At the same time, unless team members are seen as working together closely and collectively understanding the patients' goals, access to different members of the care team at different times may lead patients to feel they lack a relationship with a single clinician.

Relational care adapts and expands the interpersonal concept of relationship to encompass care provided by an interprofessional team. Relationships develop and relational care occurs when individuals and those who care for them know each other, feel as if they are working together, and share common goals. Relational care often develops over time and through interpersonal continuity, but it is not a guaranteed outcome. Relational care can and should be intentionally built between care teams and patients.

Patients want to be known and cared for, and clinical teams want to be a positive part of their patients' stories. Care provided with a sense of knowing, mutuality, and shared purpose builds trust and confidence that supports health.

Psychological safety is defined as a generally tacit, shared belief that the team—in this case the clinical team and the person together—is “safe for interpersonal risk taking.”¹⁰ When patients believe their clinical teams know them, listen to them, believe them, and act on their behalf, they receive better, more

person-centered care.¹¹ One common strategy is to use plain language in discussion of technical medical topics. It can also be particularly powerful to explicitly acknowledge and honor the patient's view of their own condition. Importantly, clinicians and trainees who spend time in the communities they serve are better able to build those trusting relationships.¹²

Comprehensive and Holistic

The third principle of Whole Person Care considers a person's entire life and context—not just diseases or conditions—and embodies an openness to the choices and preferences of the individual. Moreover, this approach considers deeply the four dimensions of a human being – the physical body and external environment, their behavior and lifestyle, their social and emotional life, and their mental and spiritual core. The concept of “treatment” should also be expansive, guided by the patient and inclusive of the wide range of modalities individuals seek to enhance their well-being beyond a diagnosis. Any given system of care delivery may not be competent in all modalities, but when care is centered on the whole person, it is open to all care that supports their health and flourishing. While comprehensiveness is commonly used to describe the full range of services provided through primary care, here the concept of comprehensiveness is broader, includes wellness approaches, and is seen from the patient's perspective. It can be summarized by the statement, **“There is nothing about you or of interest to you that is not important in your health and care.”**

One crucial component of supporting people in their health and well-being journeys is encouraging patient engagement and self-efficacy. While a clinical team cannot change another person's behavior for them, the team can make behavior change easier by increasing that person's confidence in their ability to change. Some strategies include making self-care manageable by “right-sizing” changes, offering health coaching to overcome barriers, and celebrating small wins. Teams might also ask what patients already do in order to build on existing practices or co-define measurable outcomes with the patient. In some practices, behavioral health consultation and peer groups focused on lifestyle change are used to encourage and enhance self-efficacy.

Lifestyle medicine is a discipline that relies upon “therapeutic lifestyle interventions” to treat chronic illness and promote healthy behaviors, including behavior change. These interventions incorporate nutrition, physical activity, sleep, stress management, avoidance of risky substances, and positive social connection and rely on an understanding and use of the science of behavior change to motivate patients to embrace healthier alternatives to current lifestyle choices.^{9,13} To achieve this behavior change, lifestyle medicine utilizes existing healthcare processes in different ways. For example, a clinical team might write a prescription for exercise rather than medication as a treatment for hypertension. Lifestyle medicine often relies more on community care; specifically, it may require aspects of the built environment (e.g. safe places to walk, local healthy food availability) to be present. Lifestyle medicine offers a vision for

reorientation of both primary care and specialty care toward wellness and health creation (salutogenesis), emphasizing the strengths and self-efficacy of individuals in pursuit of their health and life goals.¹⁴

CIH services incorporate practices and modalities such as acupuncture, massage, yoga, wellness coaching, and meditation that are frequently not part of the conventional healthcare system.² Many of these modalities are sometimes available in and paid for through primary or specialty care (e.g. acupuncture), but others operate exclusively outside of the insurance-based healthcare system (e.g. energy healing). Indian Health systems, both federally administered and Tribally owned and operated, are increasingly integrating indigenous medicine into their care delivery systems. Delivery of Whole Person Care includes an openness to and understanding of these options and opportunities, guided by the preferences of the individual and by the cultural norms and practices of the community or Tribe. The South Central Foundation is an Alaska Native health care system that integrates these components through its Nuka system of care.. Among its many innovative features is the incorporation of community gatherings in which members of the community can share their stories and listen to others share theirs—reflecting an important Alaska Native value and increasing access to behavioral health services.²

Whole Person Care has to take into account social and structural drivers of health, root causes of ill-health, and systemic inequities, expanding the concept of “treatment” to those social drivers of health that both directly impact on health (often referred to as health-related social needs) and those that predispose or create vulnerability to illness and impaired function. For most people, these needs, if addressed at all, are addressed through social service agencies and charitable organizations in the community. Many primary care practices already screen for some health-related social needs and offer referrals to social services or offer services themselves to help address those drivers. Most state Medicaid programs recognize and address needs such as transportation and the need for personal care. Some commercial payers have tested programs supplying housing and food support for populations with high needs in these areas.¹⁵ Whole Person Care makes visible the structural and social drivers of health and health-related social needs, and makes it part of care to work with the individuals finding pathways to address them.

Accountability and Accompaniment

The fourth principle of Whole Person Care recognizes that this vision for care requires an organizational commitment to the health and flourishing of both people and communities. While the organizational and personal commitment to the individual is addressed in part through the principle of Trusting Relationship, accountability for the population provides a lens through which the organization sees not only those seeking care at any given moment, but also those whose health and wellness are within the sphere of responsibility of the organization, whether they actively seek care or not. It provides a view of health and wellness and a scope of action outside of the office visit or phone or portal interaction.

Many health systems that have responsibility for defined populations—such as the Veteran’s Health Administration and the Indian Health Service and Tribal and Urban Indian Health Programs—take a population approach to health management. So do many healthcare systems that take responsibility for the cost, health outcomes, and experience of care for their populations through value-based care arrangements. Global budgeting models, such as the Oregon Community Care Organization or the Maryland Global Budget payment system, seek to foster better integration of physical health, mental health, addiction services, dental care, acute and subacute care, and social services at a population level.

Accountability for a population is often expressed or understood through measures of population health and clinical quality. The elements described as the Quadruple Aim (health outcomes, patient and provider experiences, and cost of care) as well as equity measures are the core domains of accountability. Any one outcome (e.g. costs) cannot be used as a primary driver without a more whole-systems assessment of the offsets in other central outcomes. Person Reported Outcome Measures (PROMs) such as the Person-Centered Primary Care Measure (PCPCM) can be used to capture the likelihood that the principles of whole person care (such as trusted relationships) exist and are embedded in care. Using patient reported outcomes such as the PCPCM also allows the system to replace and so de-burden their system administrators and providers with less important surrogate outcome measures that are often distant from actual health and wellbeing.

While population-level accountability involves analysis and planning at the level of the population served or care team panel, accountability for the individuals is often expressed through plans of care. Most care planning in primary and specialty care is problem-focused, but care plans such as those used in the VA Whole Health approach,² the HOPE integration approach,¹⁶ and in many Palliative Care and Geriatric Assessment models explicitly integrate values, preferences, and health goals into the plan. Care plans used in rehabilitation services (e.g. physical and occupational therapy) are usually guided by the individual’s goals for function and relief of symptoms. In person-centered care planning for individuals living with disabilities we see a model of co-development of plans for care, driven by the preferences and health goals of the individual. Care plans are called upon to accomplish many things; in Whole Person Care the process of planning for care and documenting that plan functions to guide care toward what matters to the patient (shared purpose) and to establish joint accountability and accompaniment (mutuality) in care and in life toward that end.

Interprofessional Teams and Coordinated Care

The fifth principle of Whole Person Care describes the delivery of care that is collaborative, coordinated, and team-based. Team-based care is a key feature of high-quality primary care, as defined by the NASEM report,¹ and the design of core and extended health care teams and an extended community care team provides a powerful operational approach. Effective interprofessional teams are at the center of high-quality primary care delivery and can incorporate different roles and configurations based on the

communities and populations they serve and should be supported by system leadership and structures (e.g. health IT, financing). **Clinical teams work best when they are stable, reflect the culture and values of their communities, and practice active teamwork** (Figure 5). Team-based care is often implemented as a way of increasing efficiency and improving access in primary care. In Whole Person Care, teams must be optimized for relational care.

Figure 5: Strategies for Improving Teamwork

- Make community members and family members part of the team
- Identify and utilize patient advocates (e.g. health coaches)
- Assign team members—including non-clinical members—to patients based on the patients' needs
- Organize team-building exercises to understand the role each team member plays
- Enable protected time for team-building, training, and relationship-strengthening
- Create easy pathways (with and without technology) for teams to communicate
- Participate in team huddles and registry-driven, structured case conferences (e.g. PACE)

The interprofessional primary care team is the core of a much broader group of interrelated providers of healthcare and social care. One of the roles of high-quality primary care is to play the role of coordinator of care by organizing other kinds of care with the person at the center. To deliver Whole Person Care in a coordinated fashion, primary care teams can use tested and effective practices of closed-loop referrals with specialty and acute care and community care. Practices and systems can maintain lists of care resources for specialty care, social services, CIH services, the built environment and wellness organizations (e.g. walkable green spaces), and faith and community organizations relevant to the communities they serve. Having relationships that allow smooth coordination with these services allows teams to effectively integrate those services into care in a responsible way. While primary care may serve as the coordinator, all three settings of care must participate for Whole Person Care to be successful. The network of relationships that develops from this work brings great value to patients and is a critical enabler of Whole Person Care.

There are models of coordination and integration that enable Whole Person Care outside of high-quality primary care. The Program of All-Inclusive Care for the Elderly (PACE) model provides Whole Person Care for frail, nursing home-eligible elderly through a co-located interprofessional care team.¹⁷ Comprehensive community-based cancer programs seek to provide oncology care that is Whole Person focused, through integrated, interprofessional teams.¹⁸

Implementing the Reframe

The central force for moving any of the above drivers of health forward with an individual is creating a trusted bond (attachment) between the clinical team and the patient's team (family, friends, advisors, technologies). The depth of this relationship (principle 2) allows the core motivation and meaning for the patient to emerge (principle 1) and is necessary for the outcomes being sought in health care (principle 4). No amount of money can make this happen, but sufficient investment is needed to enable it to happen. What makes it happen is the depth of attachment between the clinician and patient; a force that is often described as deep mutual caring and love. That attachment leads to the four Starfield C's of effective and high-quality primary care out of which better health, lower cost and high satisfaction occur.¹⁹

Many clinical teams utilize elements of Whole Person Care processes already; some practices embrace and embody Whole Person Care as a whole. But implementing and spreading Whole Person Care across the US healthcare system will require both local and system-level change. Currently, efforts to implement Whole Person Care are characterized by working within existing systems to make relatively small changes to care at the local level. For instance, some practices have reorganized their teams based on financing and local community needs. Others have performed needs assessments with their local communities to determine those needs. Some have incorporated tools and practice improvement models to streamline and improve efficiency and delivery of Whole Person Care.⁴ These local efforts promise some spread of Whole Person Care, but reaching every patient, every time will require a far more systematic approach.

Scaffolding for Implementing and Spreading Whole Person Care

Reorienting the care provided by the existing US healthcare system is possible, but it will not happen without intentional effort. Delivering Whole Person Care consistently across the system will require setting in place “scaffolding” or operational elements that work within existing settings to support the processes of Whole Person Care delivery. Without these changes, it falls to the heroic individual clinician, clinical team, or practice to deliver Whole Person Care in an environment that, in many cases, actively undermines this approach to care.

One way of envisioning this system scaffolding is to name critical levers for care delivery and, adopting the perspective used in the two cornerstone NASEM reports, identify the changes needed at the level of the patient and clinical team (micro), at the level of the practice, hospital, or health system (meso), and at the level of financing, regulation, and policy (macro). It is also important to be intentional about who is “at the table” when the scaffolding is being designed. For example, improving processes for primary care to interact with the community will be easier and more effective if social service providers and other community-based organizations participate in co-design of services and delivery.

The following examples only begin to suggest the scaffolding that may be necessary. Further exploration and research and a more systematic approach will be needed to ensure a complete understanding of how best to support Whole Person Care at every level of the system. Ultimately, change occurs for the patient locally, in and from the community.

Team-Based Care

Delivering Whole Person Care requires more than an individual clinician. Delivering Whole Person Care to people, families, communities, and populations will require core primary care teams, extended clinical teams, and community care teams working in concert.¹ Patients, caregivers, and family members are central members of the clinical team and should be included accordingly.

Core Primary Care Teams

Core teams must be designed and trained for teamwork. This teamwork may require redefining or refining team roles and improving communication modalities and norms to ensure the team works together well. Additionally, teams may need training or other work in team building and relationship strengthening, which requires protected time. These shifts will also require other systems to support the work and relationships of the interprofessional team.

Extended Clinical and Community Care Teams

While the interprofessional primary care team is the core delivery system for Whole Person Care, that team also collaborates with specialty and acute care teams and community care teams. Currently, referral systems connect primary care and specialty and acute care though the quality of those referral systems varies. These systems need to be improved to include warm handoffs where possible, active coordination, and closed-loop strategies, supported by new technologies.

Not all primary care practices and systems are integrated well into their communities, and improving that integration requires two types of approaches: connecting primary care with social services and other community care providers as well as centering the needs of the local community within the primary care system. Increasing the integration of primary care and community care may require realignment of funding from the healthcare system to social services and other community organizations. If these community care organizations are not resourced equitably, they cannot fulfill their part in the system by delivering necessary services to patients and populations. There are many lessons to be learned from community-oriented primary care,²⁰ an extensive body of work that has developed effective processes for clinic-community integration that have largely gone unheeded in recent decades.

Training

Supporting team-based care requires new ways of training team members. Clinical training at all levels should focus on Whole Person Care practices and processes and, to the extent possible, take place in outpatient/primary care settings rather than tertiary care facilities. Moreover, clinical team members must be trained to work collaboratively to prepare them for the teamwork necessary for delivering such care. Community care team members can also be familiarized with the structures and processes of the healthcare system to better integrate Whole Person Care delivery into routine practice.

Figure 6: Team-Based Care

	Example Changes
Micro System Level	- Organize care through teams with responsibility for recognizable populations - Adapt and adopt teamwork strategies and attitudes, including psychological safety - Create time and opportunity for clinical team members to know the communities they serve and build relationships with organizations providing services in the communities - Develop communication pathways and workflows that connect and integrate primary care, extended care, and community care teams with colleagues (e.g. warm handoffs, same-day referrals, active coordination, and closing-the-loop strategies)
Meso System Level	- Organize and staff clinical operations with interdisciplinary primary care teams that have the capabilities needed to meet identified whole health needs in the community served (e.g. CHWs, social workers, health coaches, behavioral health providers, and patient advocates) - Provide time and training necessary for interprofessional team development - Implement processes for identifying community needs related to whole health (e.g. Patient/Family Advisory Council, community health needs assessment) - Implement processes integrating community-based resources into clinical care (e.g. a resource list, referral team, formal and informal opportunities to know these services) - Develop formal processes to measure the effectiveness of social service organizations and resources - Embed quality and practice improvement processes into formal organizational processes
Macro System Level	- Prioritize population health outcomes and patient experience of care over volume in mechanisms of payment - Incentivize and reduce barriers to patient attachment to primary care and behavioral healthcare teams - Include Whole Person Care and the organization of care through teams at all levels of training - Move post-graduate training out of acute/tertiary sites to outpatient sites - Rebalance funding related to health and increase funding to community care in order to increase access to services from organizations in the community meeting health-related social needs

Financing, Measurement, and Accountability

Supporting the delivery of Whole Person Care by interdisciplinary and community care teams will require realigned financing mechanisms at all levels. In primary care, specifically, most care should be paid for based on clinical team accountability and people's relationships with the clinical team rather than on volume of visits or isolated transactions. This realignment of financing will help protect the time for teamwork, relationship building, integrating primary and community care, and other operational elements necessary for Whole Person Care.

Assessing the success of Whole Person Care delivery will require new ways of measuring care. Within primary care, measures can be reframed from disease-focused to people-focused. Health outcomes (e.g. HbA1c levels) remain important, but they are joined by measures of relationship, goal-driven care, community focus, patient experience, and the well-being of the clinical teams providing care. Person-reported outcome measures (PROMs) become important. Measures like the Person Centered Primary Care Measure (PCPCM)²¹ and the Whole Person Health Index (WPHI)²² are examples. Changing payment strategies will also require shifting the focus from cost-effectiveness to cost-value measures. Benefits can be measured at the social level (e.g. school attendance, student reading level) in addition to the health outcome and relationship level in order to capture the positive effects of improving individual and community health. For instance, investment in community health brings broader economic benefits,²³ which can then become key measures for organizations attempting to shift population health.

Realigning and broadening measurement strategies is a large undertaking and an area of active learning. The right measurement strategies also contribute to a necessary research and quality improvement agenda. While there are many processes that can help reframe the system to deliver Whole Person Care, it is important to track how those existing elements (and any newly introduced elements) are functioning and whether the system is helping patients achieve their goals in order to continuously improve the delivery of Whole Person Care. Similarly, elements like lifestyle medicine and high-quality primary care enjoy robust evidence bases already, but other elements such as eliciting patient stories are less well studied. These gaps in the research can be filled through well-designed measurement strategies and a robust research agenda. Implementing Whole Person Care at scale will require not only more evidence but also new ways of generating evidence, bringing together implementation science, practice-based research networks, community-based participatory research, complexity science, and learning health systems.

Redefining measurement strategies must take place alongside realigning accountability at all levels of the system. Currently, clinical teams as well as practice and system leadership are accountable for disease-focused and volume-focused measures. In a system supporting Whole Person Care, they must be accountable for people-focused and well-being-focused measures.

Figure 7: Financing, Measurement, and Accountability

	Example Changes
Micro System Level	■ Use existing payment mechanisms to fund Whole Person Care delivery (e.g. time-based billing, advanced primary care management, care preferences discussions) ■ Increase use of patient-reported measures at the panel and population level (e.g. Patient-Centered Primary Care Measure) ■ Rebalance accountability measures to reinforce processes of care that support relational care and care reflecting the patient's goals ■ Structure and pay for workforce adequately configured to support Whole Person Care
Meso System Level	■ Move population-based funding into primary care to enable delivery of services oriented to Whole Person Care, and track funds to ensure they are used to support frontline teams ■ Use hybrid and capitation financing to support integration of the core primary care, extended clinical, and community care teams ■ Align payment at all levels of the system (care teams, administrative and management, and C-suite) to incentivize the delivery of Whole Person Care ■ Redesign measurement to align with actual delivery of Whole Person Care ■ Utilize evidence to determine the optimal panel size to support accountability and accompaniment by care teams
Macro System Level	■ Develop reasonable cost estimates to implement the changes necessary to reorient the healthcare system to Whole Person Care ■ Realign financing in ways that support Whole Person Care (e.g. global budgeting, population-based payments that include community health outcomes and incentivize longitudinal relationships, and all-payer models) ■ Implement incentives for organizational commitment to whole health and Whole Person Care (e.g. revision of the application of the IRS Community Benefit Standard) ■ Enhance the measurement of Whole Person Care delivery, building on existing measurement strategies (e.g. Person-Centered Primary Care Measure) ■ Include measures of community health and social return-on-investment (e.g. high school completion rates) while acknowledging that the healthcare system is only one actor among many who influence these outcomes ■ Develop a measurement framework for payers, purchasers, and systems that aligns with delivery of Whole Person Care through clinical and community-based systems ■ Implement hybrid payment as described in the 2021 NASEM primary care report as a core payment model for primary care ■ When prospective, capitated per-person-per-month payment includes full risk, adjust payment on health and satisfaction outcomes

Electronic Health Records/Health Information Technology

Given the centrality of EHRs and health IT (including, increasingly, AI) to care delivery, these technology systems will need to be realigned to support delivery of Whole Person Care. Specifically, EHRs must be recentered on care and relationships. Additionally, at all levels, technology systems must be interoperable to encourage smooth transfer of data with attention to privacy concerns. Finally, as AI and other technologies promise to disrupt the way care is provided and the way systems are administered, that technology must be integrated into practice in ways that support rather than undermine Whole Person Care by facilitating deeper relationships, not substituting technology solutions for relationships.

Figure 8: EHRs/Health IT

	Example Changes
Micro System Level	■ Enable visibility into panel health, population health, and community health within the health information system ■ Enable EHRs and patient portals to connect patients with relevant community-based organizations and services
Meso System Level	■ Re-orient EHRs around health goals and personal health plans rather than billing ■ Redesign problem lists and care plans to better capture non-diagnosis/non-billable goals and concerns (e.g. a wellness-oriented care plan, functional goals, HOPE visits) ■ Enable EHRs to capture and convey patient stories, goals, plans, and purpose (e.g. audio record story and link to accurate AI-generated summaries in EHR) ■ Use a common, simplified personal health plan across all levels of the system (including community-based care).
Macro System Level	■ Design EHRs/health IT for care integration, between clinical teams and between clinical and community-based teams ■ Establish data interoperability and transparency to encourage informational continuity ■ Build on health information exchanges, the Trusted Exchange Framework and Common Agreement (TEFCA), and other interoperability or data sharing efforts to enable population-based views of health and provide deep insight into each individual's experience of health and health care ■ Build in privacy and ethical principles and harm reduction evidence into health-related AI systems (e.g. ChatGPT Health, etc.)

Data-Driven Communication About Whole Person Care

While Whole Person Care is built on existing processes in the healthcare system, it does present a novel reframe of care that must be communicated to everyone involved: patients, clinical teams, systems, policymakers, payers, and others. This communication can include why Whole Person Care is important and why it is important now and can take many forms to reach multiple audiences. Specific responsibilities for each stakeholder need to be clarified and communicated.

It is crucial that communication about Whole Person Care with all audiences is driven by data and strong evidence. Understanding Whole Person Care’s impact on measures of interest—such as patient experience and goal-concordant care—is a first step in both reorienting the system and building buy-in from all relevant audiences.

Figure 9: Data-Driven Communication About Whole Person Care

	Example Changes
Micro System Level	■ Create messaging and educational materials for patients using multiple modes of communication to help people understand Whole Person Care, what it means to them, and how the clinical team helps provide it, engaging them as full partners in the reorientation of the health system toward Whole Person Care ■ Use safety, efficacy, and outcomes data to communicate with patients the effectiveness of Whole Person Care
Meso System Level	■ Engage in multiple ways of listening (e.g. survey, focus groups, comment boxes, search data) to understand the orientation of the community served toward Whole Person Care ■ Target messaging on Whole Person Care to the interests and values of the community served (e.g. community-specific messaging toolkits)
Macro System Level	■ Fund research to provide the data needed to understand the impact of Whole Person Care on individual and population health outcomes and patient experience ■ Create and use messaging based on safety, efficacy, and outcome data to explain Whole Person Care to relevant populations ■ Advocate for payment reform that will provide the revenue needed to support Whole Person Care research and delivery

Conclusions

Whole Person Care has the potential to improve healthcare delivery, population-health outcomes, and the experience of care and of caring in the US healthcare system. While Whole Person Care can be built out of existing elements of the system, it will not emerge without a reframing of the goals of healthcare and a reorientation of the delivery of that care, based on good evidence—evidence that is both rigorous and relevant.

There is a great deal of evidence to work with, and much of that evidence has already been summarized in the cornerstone NASEM reports on high-quality primary care¹ and whole health.² Importantly, the questions to be asked are not abstract or theoretical, but instead quite pragmatic. What is the expected impact from care that adheres to the principles and practices of Whole Person Care, and what is the investment required to achieve that impact? What are the training and workforce requirements to enhance capabilities for this type of care? What policy and payment changes are needed to drive the spread of this care? What are the best approaches to address the challenges and conflicts of interest opposed to Whole Person Care, and how can they be influenced? Much evidence that can help answer these practical questions has been generated over years of research and practice, although rarely in rigorously controlled trials. This rich but nonsystematic literature, including evidence gleaned from models tested through the Center for Medicare & Medicaid Services (CMS) Innovation Center, has much to add and will help to identify important areas for future research. A systematic approach to understanding the current evidence for impact of Whole Person Care is an essential next step.

New evidence development requires asking the right questions and generating the rigorous knowledge that people can use to accomplish their goals. A reorientation of the US health system toward Whole Person Care requires engagement of federal, state, and philanthropic funders willing to support researchers who want to answer questions related to broad adoption of the delivery of that care.

Some of the work of moving toward Whole Person Care is already underway. The NASEM high-quality primary care report¹ outlines a clear and actionable implementation plan for primary care; that agenda is also part of the definition and implementation agenda for Whole Person Care. There continues to be momentum among commercial and public payors toward payment models that provide both the flexibility and incentives needed for Whole Person Care, and CMS and states are partnering in global payment through the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model, adjustments to the Physician's Fee Schedule, and Advanced Primary Care Payment models. The Veterans Administration, the largest health system in the US, continues to invest and innovate in Whole Person Care. These payment reform efforts should explicitly address both funding levels and payment mechanisms that support Whole Person Care.

This report aims to capture an emerging consensus on the elements that constitute Whole Person Care and suggests that existing institutions and systems of care can be organized to deliver on the promise of Whole Person Care. It points the way toward a systematic and comprehensive articulation of the elements and processes of Whole Person Care and a roadmap for research and implementation.

Powered by a consensus vision for Whole Person Care and a clear implementation roadmap we can reorient our healthcare system toward health with Whole Person Care for every patient, every time, everywhere.

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Appendix A: Summit Participant Bios

Thank you to the participants below for their steadfast dedication and commitment to whole person care.

Andrew Bazemore, MD, MPH

Andrew Bazemore MD, MPH, is Senior Vice President, Research & Policy at the American Board of Family Medicine. Dr. Bazemore is also co-director of the Center for Professionalism and Value in Health Care. Before this he was the Director of the Robert Graham Policy Center, where he oversaw research and projects related to access to care for underserved populations, health workforce, spatial analysis and health, and more. Dr. Bazemore is a faculty member of the departments of family medicine at Georgetown University and Virginia Commonwealth University (VCU), and in the department of health policy at George Washington University School of Public Health. He's a practicing family physician and teaches students and residents at VCU-Fairfax Family Medicine Residency program, and is an elected member of the National Academy of Medicine and appointed member of the federal Council on Graduate Medical Education.



Asaf Bitton, MD, MPH

Dr. Bitton is the executive director of Ariadne Labs, a health systems innovation center at Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health. He is an Associate Professor of Medicine and Health Care Policy at both Harvard Medical School and the Harvard T.H. Chan School of Public Health.



A globally-recognized leader in health systems innovation, he leads Ariadne Labs' efforts to design, test, and spread scalable systems-level solutions that improve health care processes, enhance purposeful interactions between patients and their providers, and impact populations at scale.

As a practicing primary care physician and expert in primary health care policy, financing, and delivery, he has served as a senior advisor for primary care policy at the Center for Medicare and Medicaid Innovation since 2012. He has helped design and test three major comprehensive primary care payment and delivery initiatives, representing the largest tests of combined primary care payment and clinical practice transformation work in the United States. He currently serves on the Center for Strategic and International Studies Bipartisan Commission on Strengthening America's Health Security, the National Advisory Council

for Healthcare Research at the Agency for Healthcare Research and Quality in the U.S., and is an elected member of the International Academy of Quality and Safety.

Carolyn Clancy, MD, MACP

Dr. Clancy serves as the Assistant Under Secretary for Health (AUSH) for Discovery, Education & Affiliate Networks (DEAN), Veterans Health Administration (VHA), effective July 22, 2018. The Office of the DEAN fosters collaboration and knowledge transfer with facility-based educators, researchers and clinicians within VA, and between VA and its affiliates.



Prior to her current position, she served as the Acting Deputy Secretary of the Department of Veterans Affairs, the second-largest Cabinet department, with a \$246 billion budget and over 424,000 employees serving in VA medical centers, clinics, benefits offices, and national cemeteries, overseeing the development and implementation of enterprise-wide policies, programs, activities and special interests. She also served as the VHA Executive in Charge, with the authority to perform the functions and duties of the Under Secretary for Health, directing a health care system with a \$68 billion annual budget, overseeing the delivery of care to more than 9 million enrolled Veterans. Previously, she served as the Interim Under Secretary for Health from 2014-2015. Dr. Clancy also served as the VHA AUSH for Organizational Excellence, overseeing VHA's performance, quality, safety, risk management, systems engineering, auditing, oversight, ethics and accreditation programs, as well as ten years as the Director, Agency for Healthcare Research and Quality.

She is a highly experienced and nationally recognized physician executive. Dr. Clancy is a general internist and health services researcher, a graduate of Boston College and the University of Massachusetts Medical School. She holds an academic appointment at George Washington University's School of Medicine and serves as Senior Associate Editor, Health Services Research Journal. She has contributed to eight academic textbooks and authored, co-authored and provided invited commentary in more than 225 scholarly journal articles. She served as member of the National Quality Forum's Board of Directors, Chair of the AQA Alliance and served on the Board of Governors for the Patient-Centered Outcomes Research Institute. She is an elected member of the National Academy of Medicine and was presented with the 2014 Quality Champion Award from the National Committee for Quality Assurance. She was also named as an Honorary Fellow of the American Academy of Nursing and was selected as the 2015 Outstanding Federal Executive of the Year by Disabled American Veterans. In 2018, she was selected as one of the Top 50 Physician Executives by Modern Healthcare, and in 2019, she was identified as one of the 50 Most Influential Clinical Executives by Modern Healthcare.

Deborah Cohen, PhD

Dr. Cohen is an implementation scientist and an expert in qualitative and mixed methods. Dr. Cohen's research examines the interpersonal and organizational aspects of health care delivery with a particular focus on primary and behavioral health care. She examines the challenges that emerge when implementing innovations and quality improvements in primary care practices. Her research highlights the often-invisible work of professionals on primary care clinical teams.

Dr. Cohen and her team are currently studying the staffing configurations of advanced primary care practices (professionals, roles, functions) in the United States (U.S.), and the implementation and impact of state and federal policy changes on health care, with a particular focus on primary care payment, and substance use and mental health treatment. Dr. Cohen is a National Academy of Science Engineering and Medicine (NASEM) member, and she currently serves the NASEM Standing Committee for Primary Care, which is an advisory committee to the federal government on primary care.

Dr. Cohen has a Ph.D. in communication, where she studied interpersonal and organizational communication. She was trained in qualitative and quantitative methods, with an emphasis on applying ethnomethodology and conversation analysis to health-related communication.

**Rebecca Etz, PhD**

Rebecca S. Etz, PhD, is a cultural anthropologist, Co-Director of the Larry A. Green Center for the Advancement of Primary Health Care for the Public Good, and a Professor of Family Medicine and Population Health at Virginia Commonwealth University. Dr. Etz has expertise in qualitative research methods and design, primary care measures, theory of family medicine and primary care, practice transformation, and engagement of stakeholders. She has spent the last 20 years developing deep national relationships working with practices and policy makers on primary care related measurement, professionalism and vision. Prior work has also included bridging the boundaries between primary care practices, behavioral health, and community resources. Dr. Etz has also held many national leadership positions, including co-director of a large practice-based research network, Board member of the North American Primary Care Research Group, and Board member of the Center for the History of Family Medicine.



Bruce Finke, MD

Bruce Finke, MD is Senior Advisor for Primary Care at Ariadne Labs. In this role he works across the organization to support prototype development and implementation efforts focused on the organization and delivery of care for individuals and populations. Bruce draws upon his substantial experience in the design and delivery of primary health care in the U.S. to engage and advise with our partners organization on strategies for making health systems more responsive, efficient, and effective. He also serves as a mentor to our clinical and policy research teams.



In over 30 years in government health care, Bruce served in leadership roles in the Indian Health Service and the CMS Center for Medicare and Medicaid Innovation and worked across agencies on multiple policy initiatives. He led policy and program development in geriatrics and long term services and support at the Indian Health Service for over 25 years while serving in a variety of administrative roles at the regional and national level and maintaining an active clinical role. As a senior advisor in the Learning and Diffusion group at the Center for Medicare and Medicaid Innovation from 2011 through 2024, he led design of the systems to support learning within and from multiple models of care delivery and payment reform, with a special focus on primary care and dementia services. He served on the HHS Advisory Council for Alzheimer's Research, Care and Services from its inception in 2011 until his retirement from federal service in 2024 and was recognized with the HHS Career Achievement Award in 2023.

In addition to his role at Ariadne Labs, Dr. Finke now practices in Northampton, MA, supporting the comprehensive, person-centered primary care provided at the Valley Medical Group with geriatric consultation.

Ann Greiner

Ann Greiner serves as President and Chief Executive Officer of the Primary Care Collaborative (PCC), where she is focused on defining and implementing an advocacy, research and education agenda that furthers comprehensive, team-based and patient-centered primary care.

Ms. Greiner is a well-recognized leader in the quality field and has worked at a number of prestigious national organizations. Prior to joining the PCC in 2017, she served as Vice President of Public Affairs for the National Quality Forum (NQF), where she increased the visibility and influence of NQF on Capitol Hill. She also served as



Deputy Director at the National Academies of Medicine, contributing to the Quality Chasm series of reports and related conferences. Ms. Greiner has also held leadership positions at NCQA and the American Board of Internal Medicine. She has a master's degree in Urban Planning from the Massachusetts Institute of Technology and a Bachelor of Arts degree in English Literature from Hobart and William Smith Colleges.

Lauren S. Hughes, MD, MPH, MSc, MHCDS, FAAFP

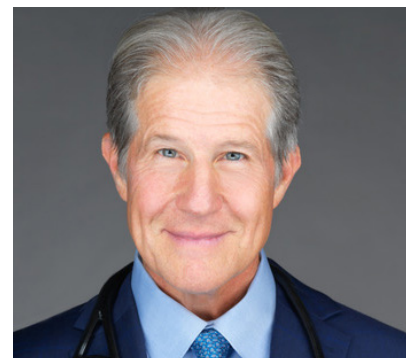
Lauren S. Hughes, MD, MPH, MSc, MHCDS, FAAFP, is the state policy director of the Farley Health Policy Center and associate professor of family medicine, both at the University of Colorado, where she researches how to strengthen primary care infrastructure, transform rural health care delivery, and advance behavioral health integration. Dr. Hughes previously served as Deputy Secretary for Health Innovation in the Pennsylvania Department of Health, where she launched the state's Prescription Drug Monitoring Program and the Pennsylvania Rural Health Model, a new payment and delivery model co-designed with the CMS Innovation Center that transitions rural hospitals from fee-for-service to multi-payer



global budgets. Dr. Hughes is a former chair of the American Board of Family Medicine and an alumna of the Robert Wood Johnson Foundation Clinical Scholars Program. She currently serves as chair of the Rural Health Redesign Center Organization Board of Directors and is a member of the Primary Care Payment Reform Collaborative convened by the Colorado Division of Insurance. In 2018, she was selected as a Presidential Leadership Scholar by Presidents Clinton and Bush, and in 2023, she was named as the co-chair of the National Academies of Sciences, Engineering, and Medicine Standing Committee on Primary Care. In 2026, along with co-editors Drs. Anthony Cheng and Jen DeVoe, she published the textbook "Primary Care in a Public Health Emergency: Lessons from the Frontlines of the COVID-19 Pandemic" through Springer.

Wayne Jonas, MD

Wayne Jonas, MD, is a board-certified, practicing family physician, an expert in integrative health and whole person care delivery, and a widely published scientific investigator. Additionally, Dr. Jonas is a retired Lieutenant Colonel in the Medical Corps of the United States Army. From 2001-2016, he was President and Chief Executive Officer of Samueli Institute, a non-profit medical research organization supporting the scientific investigation of healing processes in the areas of stress, pain and resilience.



Dr. Jonas wrote the best-selling book *How Healing Works*, laying out a revolutionary new way to approach injury, illness, and wellness. He also co-authored a second book with Alyssa McManamon, MD, *Healing and Cancer: A Guide to Whole Person Cancer Care*. This book is meant to be actively used by teams caring for people with cancer and by caregivers and patients to enhance healing, health, and wellbeing.

Dr. Jonas was the Director of the Office of Alternative Medicine at the National Institutes of Health from 1995-1999, and prior to that served as the Director of the Medical Research Fellowship at the Walter Reed Army Institute of Research. He is a Fellow of the American Academy of Family Physicians.

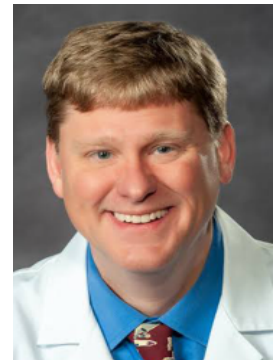
His research has appeared in peer-reviewed journals such as the *Journal of the American Medical Association*, *Nature Medicine*, the *Journal of Family Practice*, the *Annals of Internal Medicine*, and *The Lancet*. Dr. Jonas received the 2015 Pioneer Award from the Integrative Healthcare Symposium, the 2007 America's Top Family Doctors Award, the 2003 Pioneer Award from the American Holistic Medical Association, the 2002 Physician Recognition Award of the American Medical Association, and the 2002 Meritorious Activity Prize from the International Society of Life Information Science in Chiba, Japan.

Dr. Jonas is currently the President of Healing Works Foundation, a not for profit organization dedicated to the integration of healing and curing in routine health care delivery.

Alex Krist, MD, MPH

Alexander H. Krist, MD, MPH is an associate professor of family medicine and population health at Virginia Commonwealth University and active clinician and teacher at the Fairfax Family Practice residency. He is co-director of the Virginia Ambulatory Care Outcomes Research Network, director of community-engaged research at the Center for Clinical and Translational Research, and a member of the U.S Preventive Services Task Force.

His areas of interest include community engagement, implementation of preventive recommendations, patient-centered care, shared decision-making, cancer screening, and health information technology. He is the primary author of numerous peer-reviewed publications and has presented to a wide range of audiences at national and international conferences.



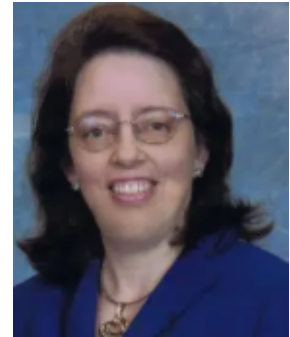
Dr. Krist has been one of the leading thinkers on how to operationalize U.S. Preventive Services Task Force recommendations in clinical practice and has been an innovator in the use of health information technology to promote implementation of recommended services. Working closely with patients and practices, he has invested years in developing an online personal health record that uses complex

heuristic programming rules to tailor USPSTF recommendations to individual patients, engage patients in their care, and offer decision support to patients, clinicians, and practices.

Sharyl Nass, PhD

Dr. Nass attended the meeting because of the focus on past NASEM consensus reports, but she did not participate in drafting or editing this meeting summary.

Sharyl J. Nass, PhD, serves as Senior Program Director for Health Care and Public Health at the National Academies of Sciences, Engineering, and Medicine. The National Academies provide independent, objective analysis and advice to the nation to solve complex problems and inform public policy decisions related to science, technology, and medicine. The Health Care and Public Health program addresses the delivery of primary and specialty health care across the life course, including care quality and patient safety, workforce, training, and financing, as well as public health services, including prevention, surveillance, epidemiology, and population health improvement. For more than 25 years, Dr. Nass has worked on a broad range of health and science policy topics that includes cancer research and care, the quality and safety of health care and clinical trials, developing technologies for precision medicine, and strategies to support clinician and patient well-being. She has a Ph.D. from Georgetown University and undertook postdoctoral training at the Johns Hopkins University School of Medicine, as well as a research fellowship at the Max Planck Institute in Germany. She also holds a B.S. and an M.S. from the University of Wisconsin–Madison. She has been the recipient of the Cecil Medal for Excellence in Health Policy Research, a Distinguished Service Award from the National Academies, the Institute of Medicine staff team achievement award (as team leader), and the Health and Medicine Division Mentor Award.



Bob Phillips, MD, MSPH

Robert L. Phillips, Jr., MD, MSPH, is founding executive director of the Center for Professionalism and Value in Health Care, which aims to create space in which patients, health professionals, payers, and policy makers can work to renegotiate the social contract. Phillips currently practices in a community-based residency program in Fairfax, Va., and is professor of family medicine at Georgetown University and Virginia Commonwealth University. He co-chaired the Committee on Implementing High-Quality Primary Care for the National Academies of Sciences, Engineering, and Medicine. He served as a Fulbright Specialist to the Netherlands in 2012 and New Zealand in 2016. Dr. Phillips was elected to the National Academy of Medicine in 2010 and currently serves as its Home Secretary.



Purva Rawal, PhD

Purva Rawal, PhD, is the Chief Strategy Officer at the CMS Innovation Center at the Centers for Medicare and Medicaid Services. As part of the Senior Leadership team, she provides guidance and leadership on the execution of the Innovation Center's strategy.



Most recently, she was a principal at CapView Strategies, where she developed evidence-based public policy and business strategies and conducted policy research on health system transformation and sustainability issues. She was also an adjunct assistant professor at Georgetown University. In 2016, she published a book, *The Affordable Care Act: Examining the Facts* and has published book chapter, blogs, and papers on value-based care. Previously, Dr. Rawal served as professional staff on the Senate Budget Committee during the passage of the Affordable Care Act and as the health and social policy advisor to Sen. Joseph Lieberman (I-CT). She was also a director in the Health Insurance and Reform Practice at Avalere Health. She began her health policy career as a Christine Mirzayan Science and Technology Fellow at the National Academy of Sciences and as a Congressional Fellow for the Society for Research on Child Development and the American Association for the Advancement of Science. Dr. Rawal received her B.A. and Ph.D. from Northwestern University.

Sumi Sexton, MD

Sumi Makkar Sexton, MD, FAAFP, is a family physician and Editor-in-Chief of the *American Family Physician* (AFP) journal, a position she has held since 2018. She is also Editor-in-Chief of *FP Essentials* and a longtime educator at Georgetown University School of Medicine, specializing in teaching medical writing, clinical courses, and mentoring students.



Appendix B: Summit Agenda

- Welcome
 - **Dr. Asaf Bitton**, Executive Director, Ariadne Labs
 - **Dr. Wayne Jonas**, President, Healing Works Foundation
- Goals from original description of convergence meeting
 - Move toward a clear vision and description of the operational elements of and steps in whole person care that are most likely to prevent, reverse or better manage chronic disease.
 - Identify the major drivers of health (DOH) that whole person care should be able to respond to when properly operating to mitigate chronic disease and enhance wellbeing.
 - List the key support structures that need to be in place for whole person care to occur in day-to-day practice.
- **Part 1** | Anchoring whole person care
- **Part 2** | Operationalizing whole person care
- Lunch
- **Part 3** | Implementing whole person care at scale
- Reflection & Closing