National Board for
Health and Wellness Coaching

Submitted via Regulations.gov

September 14, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator, Centers for Medicare & Medicaid Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, Maryland 21244-1816

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment

Dear Administrator Oz,

On behalf of the National Board for Health and Wellness Coaching (**NBHWC**), thank you for the opportunity to comment on the CY 2027 Medicare Physician Fee Schedule (**CMS-1848-P**). NBHWC is a nonprofit credentialing body advancing education, training, certification, and research for health and wellness coaching. Since 2016, in collaboration with the National Board of Medical Examiners (**NBME**), more than 12,000 individuals have earned the National Board Certified Health and Wellness Coach (**NBC-HWC**) credential.

We strongly support the Agency's proposal to promote Medicare beneficiary access to health and wellness coaching services in CY 2027 and beyond by clarifying the conditions of payment and valuation at the national level (91 Federal Register, 43906-43907, July 16, 2026). We commend CMS leadership and staff for preparing the Request for Information last year and dedicating the time, focus, and effort to develop this important proposal.

The proposed national payment pathway for HWC is closely aligned with the Center for Medicare's recently articulated strategy for strengthening Original Medicare. Appropriately structured HWC services can support CMS's goals of aligning spending and value, empowering beneficiaries to make informed choices and pursue their health goals, and strengthening accountability through longitudinal, coordinated care. CMS has emphasized the importance of payment methodologies that support high-value care delivered "at the right place, at the right time, and in the right way," while improving access, affordability, and care coordination.

We believe the recommendations below advance those objectives by ensuring that HWC is appropriately defined, supervised, valued, credentialed, and supported by a durable Medicare payment pathway. As discussed below, our comments focus on refinement of this important proposal.

Summary of Recommendations.

Our comments and recommendations are summarized below.

I. CMS should finalize its proposal to promote Medicare beneficiary access to health and wellness coaching by clarifying the conditions of payment and valuation of health and wellness coaching services as described under CPT codes 0591T, 0592T, and 0593T.

II. CMS should finalize its proposal to establish national payment levels for health and wellness coaching services, but we urge CMS to revise the valuation and reporting of CPT codes 0591T, 0592T, and 0593T to more accurately reflect the time and resources required to furnish these services.

III. CMS should establish a durable Medicare coding pathway for health and wellness coaching, including dedicated HCPCS G-codes.

IV. CMS should finalize its proposal to require that credentialed personnel furnishing health and wellness coaching services hold an appropriate, nationally recognized, individual competency-based certification through the recognized credentialing pathways identified by CMS. NBHWC strongly supports CMS's explicit recognition of the NBC-HWC credential as a qualification pathway for furnishing HWC services.

V. CMS should clarify that CPT codes 0591T, 0592T, and 0593T are subject to general supervision—not direct supervision—by the billing practitioner. Health and wellness coaching is routinely provided under general supervision throughout the United States, and the published evidence and extensive practical experience do not identify a clinical rationale for requiring direct supervision. A direct supervision requirement would be inconsistent with longstanding and common practice, and would create an unnecessary barrier to care, especially in rural and other underserved populations where physician resources are thinly stretched.

VI. CMS should finalize its proposal to adopt the CPT prefatory language for CPT codes 0591T, 0592T, and 0593T without revision.

VII. CMS should preserve telehealth access for health and wellness coaching services.

These recommendations are discussed in greater detail below:

I. CMS should finalize its proposal to promote Medicare beneficiary access to health and wellness coaching by clarifying the conditions of payment and valuation of health and wellness coaching services as described under CPT codes 0591T, 0592T, and 0593T.

Health and wellness coaches are well positioned to help address the epidemic of chronic disease in the Medicare population and advance national health initiatives. Extensive evidence shows health and wellness coaching is associated with improved patient-centered and patient-reported outcomes, with additional evidence suggesting favorable healthcare utilization and economic outcomes. The peer-reviewed evidence base now includes more than 480 publications, including more than 140 randomized controlled trials, spanning diabetes, cardiovascular risk, weight management, COPD, multimorbidity, preventive care, and varied clinical and community settings. Across this literature, studies have reported improvements in a range of patient-centered, behavioral, and clinical outcomes.[1]

CMS's proposal is an important step toward implementing a service that supports evidence-based whole person care through healthy lifestyle support, patient engagement and motivation, and goal attainment within their healthcare needs and lived context. Health and wellness coaching helps beneficiaries translate health goals into sustained behavior change, which can improve outcomes and may reduce downstream utilization. In this way, HWC can serve as an integrative bridge between clinical recommendations and the day-to-day behavioral, social, and lifestyle factors that shape health. NBHWC supports CMS's proposal not to impose fixed frequency limitations when HWC services are reasonable and necessary. Ongoing coaching should continue to include routine documentation of goals, progress, and care-team communication within the established supervision framework. For longer episodes of care, periodic reassessment by the supervising practitioner and coach can confirm continued medical necessity and whether the care plan or goals should be continued or modified. Such reassessment should not, by itself, require an additional face-to-face visit or function as a fixed limit on the number of medically necessary sessions.

[1] Abu Dabrh AM, Weiss JM, Munipalli B, Kaye MP, Smith K, Shur E, Harenberg S, Garofalo R, Mohabbat AB, Robinson A, Paul SN, Beech BM, Moore M, Brigham TJ, Sforzo GA. Compendium of Health and Wellness Coaching: 2023 Addendum. Journal of Integrative and Complementary Medicine. 2025 Mar 28. Epub ahead of print.

As one example, in 2025 the Veterans Health Administration (**VHA**) delivered health and wellness coaching to approximately 84,000 Veterans in approximately 273,000 sessions ***under general supervision*** using HWC Category III CPT codes—demonstrating feasibility, scalable integration with care teams, and substantial real-world experience with in-person and telehealth delivery. In prior communications with CMS, we have also presented utilization data representing approximately 4.9 million HWC visits from 2015–2022 across 72 healthcare organizations, together with evidence from 34 large HWC studies, further demonstrating the substantial real-world use and evidence base supporting integration of HWC within healthcare delivery.

II. CMS should finalize its proposal to establish national payment levels for health and wellness coaching services, but we urge CMS to revise the valuation and reporting of CPT codes 0591T, 0592T, and 0593T to more accurately reflect the time and resources required to furnish these services.

We agree with CMS that establishing national payment levels for health and wellness coaching is in the best interest of Medicare beneficiaries and the Medicare program. We also agree that the Chronic Care Management codes selected by CMS provide reasonable structural analogues for valuing individual HWC services because both involve longitudinal, time-based services furnished under general practitioner supervision. However, the proposed crosswalk does not fully account for the substantially greater service time explicitly required by the HWC CPT descriptors, which, when furnished by the qualified coach, should be appropriately reflected in the direct clinical labor inputs.

Please consider the need for refinement of the valuations due to the following differences in time intervals associated with the relevant codes:

- CPT code 0591T requires at least 60 minutes for the initial individual assessment and intervention, whereas CPT code 0592T requires at least 30 minutes for an individual follow-up service.

- By comparison, there is at least a three-fold difference between the time requirements for CPT 0591T and CPT code 99490 (CPT code 99490 represents only the first 20 minutes of clinical staff time).

- Similarly, there is at least a 1.5-fold difference between the time requirements for CPT 0592T and CPT code 99439 (CPT code 99439 represents each additional 20 minutes of clinical staff time).

- CMS's CY 2027 direct PE files assign 25 minutes of intra-service RN/LPN/MTA clinical labor to CPT codes 0591T and 0592T—the same 25-minute intra-service clinical-labor input assigned to CPT codes 99490 and 99439, respectively. This unchanged input does not fully reflect the HWC service-time requirements in the CPT descriptors: 60–90 minutes for 0591T and at least 30 minutes for 0592T. ***Therefore, NBHWC recommends that CMS revise the direct clinical-labor inputs so that, when these services are furnished by qualified HWC auxiliary personnel, CPT code 0591T reflects no less than 60 minutes and CPT code 0592T reflects no less than 30 minutes of intra-service HWC clinical labor, with any separately appropriate pre- and post-service clinical-labor resources also recognized under the physician fee schedule (PFS) methodology. CMS should calculate the resulting practice expense RVUs under its standard PFS methodology.***

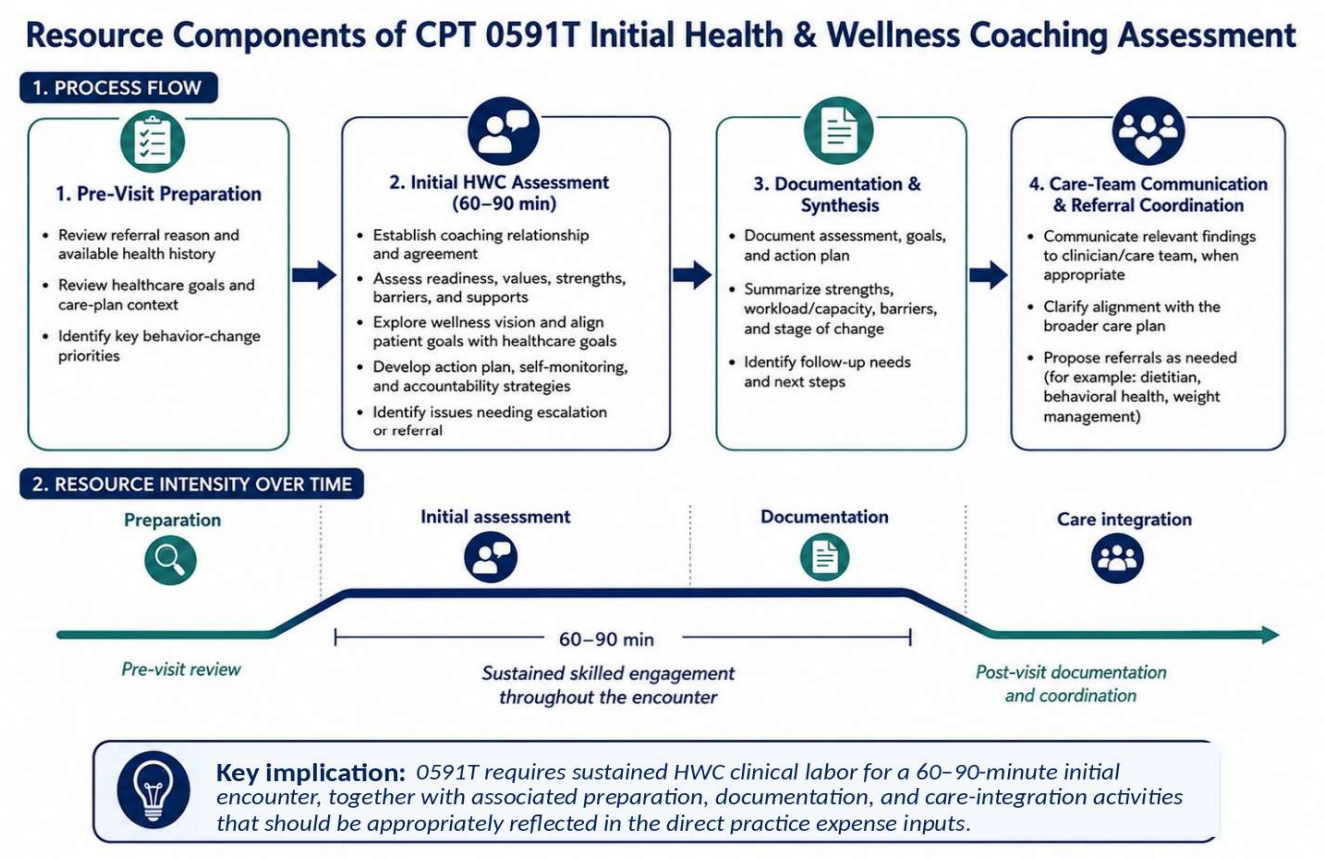
- Additionally, for CPT code 0593T, we agree that G0109 provides a reasonable 30-minute group-service analogue and recommend that CMS clarify that valuation and reporting appropriately recognize each eligible 30-minute increment of group HWC service.

CPT code 0591T represents a discrete initial assessment requiring 60–90 minutes of substantive, patient-centered engagement. The CPT prefatory language describes an integrated process that includes goal determination, self-discovery or active learning, education, self-monitoring, motivational strategies, communication techniques, and development of skills to support sustainable behavior change.

These activities, as reflected in the CPT prefatory language, unfold throughout the 0591T code encounter at a consistent intensity and are not confined to a discrete portion of the session. Based on these considerations, we support CMS's use of CPT code 99490 as the structural reference for CPT code 0591T. NBHWC's requested adjustment is directed to the direct practice expense inputs needed to reflect the service time required by the HWC descriptor. We urge CMS to revise the direct clinical labor inputs to reflect no less than 60 minutes of HWC service furnished by the qualified coach, together with the typical pre- and post-service resources appropriately recognized under the PFS methodology. Final practice expense and total RVUs should then be calculated under CMS's standard methodology.

These resources associated with CPT code 0591T are described in further detail in **Figure 1**.

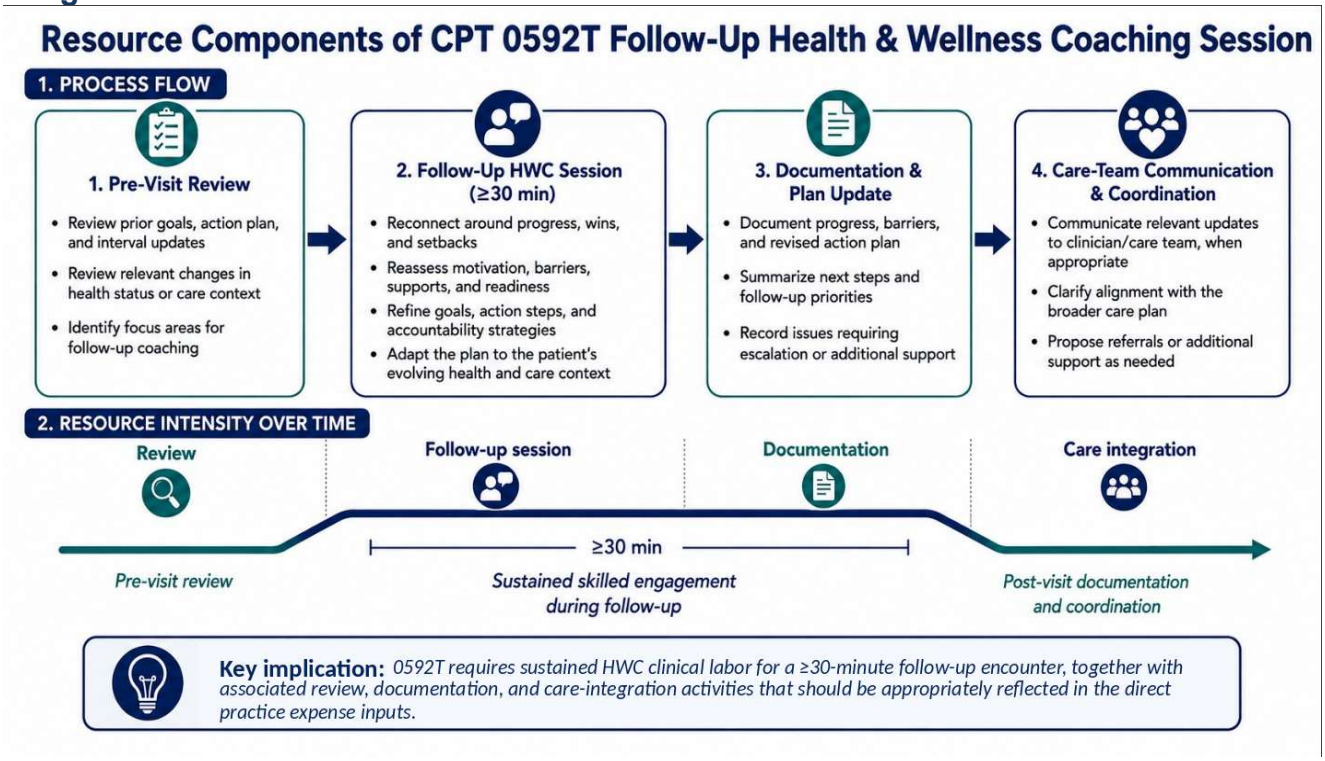
Figure 1.



Similarly, we support CMS's use of CPT code 99439 as the structural reference for CPT code 0592T. NBHWC's requested adjustment is directed to the direct practice expense inputs needed to reflect the service time required by the HWC descriptor. Because 0592T requires at least 30 minutes of HWC service, while 99439 describes an additional 20-minute CCM service increment, we urge CMS to revise the direct clinical-labor inputs to reflect no less than 30 minutes of HWC service furnished by the qualified coach, together with the typical pre- and post-service resources appropriately recognized under the PFS methodology. NBHWC further recommends that CMS identify in the final rule the clinical-labor category and direct clinical-labor minutes used in the final valuation of 0591T and 0592T, ensure that the selected labor category is an appropriate proxy for personnel qualified to furnish HWC services, and provide sufficient transparency for the resulting payment to be evaluated against the actual resource requirements of the services.

These resources associated with CPT code 0592T are described in further detail in **Figure 2**.

Figure 2.

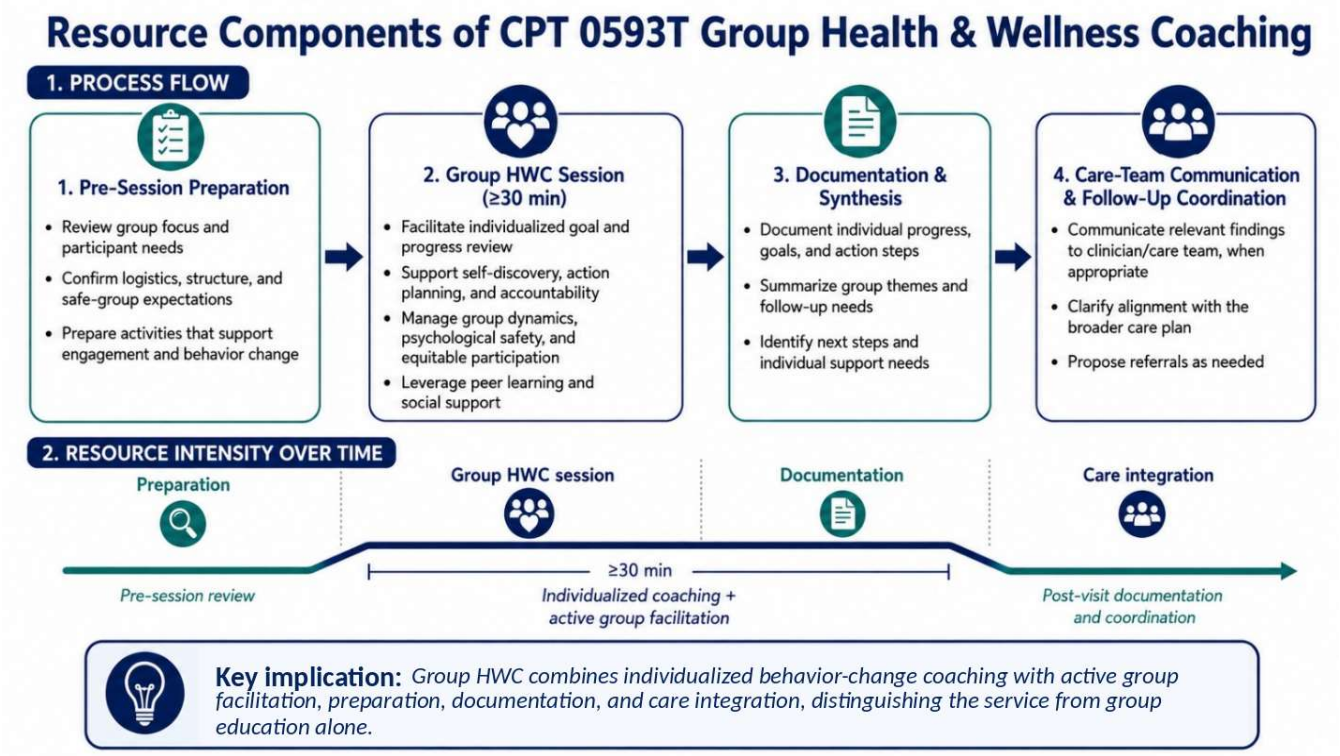


With respect to the valuation of CPT code 0593T, we support the use of G0109 as a reference base code to assign RVUs to 0593T. However, group health and wellness coaching (GHWC) is distinct from group education alone and requires additional competency in individualized behavior-change coaching and group facilitation. NBHWC has created and validated competencies for group health and wellness coaching to demonstrate that the coach must simultaneously apply individual behavior-change coaching skills while managing group dynamics, psychological safety, participation, individualized goals and progress, accountability, and group cohesion. These competencies were established through a rigorous two-phase development and validation process, including validation by 78 experienced NBC-HWCs practicing group coaching, and built upon prior NBHWC-led work supported through a CDC-

funded cooperative agreement to develop group coaching competencies and training for the National Diabetes Prevention Program.[2]

These group-specific facilitation demands underscore that group HWC is a distinct competency-based coaching service rather than group education alone. For CY 2027, however, we support CMS's use of G0109 as the 30-minute valuation analogue for CPT code 0593T and recommend that CMS clarify that valuation and reporting appropriately recognize each eligible 30-minute increment of group HWC service.

Figure 3.



The additional facilitation demands of competency-based group HWC also support NBHWC's separate recommendation in Section III that any Medicare-specific group HWC G-code recognize a standard group coaching session of at least 60 minutes.

[2] Wolever RQ, Cline TR, Weiss JM, Carmack S, Schultz C, Arloski M, Lawson K. Group Health & Wellness Coaching: development and validation of the required competencies. BMC Health Serv Res. 2024 Mar 28;24(1):392. doi: 10.1186/s12913-024-10704-x. PMID: 38549090; PMCID: PMC10976677.

The resources associated with CPT code 0593T are described in further detail in **Figure 3**.

Accurate valuation is particularly important because meaningful behavior change is individualized and time-intensive; payment should recognize the clinical labor and other practice resources required to translate beneficiary health goals into sustainable lifestyle and self-management actions that support prevention, chronic disease management, and coordinated whole person care.

Consistent with CMS's treatment elsewhere in this proposed rule of services that may be furnished through synchronous audiovisual and, where permitted under Medicare policy, audio-only telecommunications technology, health and wellness coaching is highly amenable to these modalities. Medicare has included the Category III HWC CPT codes on the Telehealth List since 2024, and health systems, including VHA, routinely deliver coaching virtually to expand access for rural and underserved beneficiaries.

***III. CMS should establish a durable Medicare coding pathway for health and wellness coaching, including dedicated HCPCS G-codes*.**

We appreciate CMS's request for comments on whether HCPCS G-codes should be established for HWC services rather than relying indefinitely on the existing Category III CPT codes. Dedicated G-codes could provide important advantages as Medicare moves toward national payment for these services.

The Category III CPT codes have played an important role in defining HWC services, supporting data collection, and enabling their use within Medicare and other healthcare settings. The growing evidence base, national credentialing infrastructure, and large-scale experience within systems such as the VHA now provide CMS with an opportunity to establish a more durable Medicare-specific coding pathway.

Dedicated G-codes would allow CMS to specify Medicare-specific conditions of payment, including applicable time requirements, supervision, credential expectations, and other programmatic parameters, while preserving the essential characteristics of the CPT-defined HWC service. CMS is likewise considering Medicare-specific HCPCS G-codes elsewhere in this proposed rule where such codes may better preserve necessary service elements and conditions of payment, providing a relevant parallel for establishing a durable Medicare-specific coding pathway for HWC.

In our surveys and communications with provider groups with dedicated coaching teams, we consistently hear that the Category III status of the HWC codes undermines coverage and payment for these services.

G-codes would provide greater support and certainty than Category III CPT codes to physician practices, health systems, community-based organizations, and other entities considering investment in the workforce, scheduling, documentation, billing infrastructure, and clinical workflows necessary to make HWC available to Medicare beneficiaries. Accordingly, we encourage CMS to establish dedicated HCPCS G-codes for HWC services beginning in CY 2027.

If CMS determines that additional development is necessary before implementing G-codes, we urge the Agency to finalize national payment for 0591T–0593T while establishing a clear pathway toward a durable Medicare coding structure beyond continued reliance on Category III status.

Any Medicare-specific G-code structure should preserve the core attributes of the existing HWC service, including patient-centered goal setting, appropriate individual competency standards, practitioner supervision, and adequate recognition of the time required to furnish the service. For group HWC, NBHWC recommends that any Medicare-specific G-code structure recognize a standard group coaching session of at least 60 minutes, reflecting our current recommendations regarding the additional time needed to support individualized goals while effectively facilitating group processes and dynamics.

IV. CMS should finalize its proposal to require that credentialed auxiliary personnel furnishing health and wellness coaching services hold an appropriate, nationally recognized, individual competency-based certification through the credentialing pathways identified by CMS. NBHWC strongly supports CMS's explicit recognition of the NBC-HWC credential.

Robust education, training, examination, and individual competency assessment are essential to the safe and effective delivery of HWC. CMS identifies NBHWC, NCHEC, and AHNCC as national credentialing pathways relevant to this requirement. NBHWC strongly supports this competency-based framework and particularly appreciates CMS's explicit recognition of the NBC-HWC credential. Through its longstanding work to establish national HWC competencies, education and training standards, practical skills assessment, and national certification—and through its collaboration with the National Board of Medical Examiners (NBME)—NBHWC has developed a rigorous infrastructure for independently verifying individual competency to furnish

HWC. A snapshot of the peer-reviewed evidence base supporting HWC delivered through structured coaching programs—including services furnished by certified coaches—further underscores the importance of consistent education, defined competencies, skills assessment, and rigorous individual certification, as summarized in **Table 1**.

Completion of a specific health-promotion or disease-prevention program does not, by itself, establish that an individual has met comprehensive national standards for HWC education, training, skills assessment, competency verification, and examination. We therefore urge CMS to narrowly define any alternative pathway and require substantially equivalent education, training, skills assessment, examination, and independent verification of individual competency.

Health and wellness coaches are qualified to perform HWC by education, training, and national examination. Their preparation includes behavior-change theory, motivational strategies, communication techniques, and health education and promotion principles used to help patients to support their autonomy, intrinsic motivation, and skills for accountable and sustainable change.[3]

NBHWC has promulgated national standards that define the core competencies and assess the knowledge, tasks, and skills essential to HWC practice. Eligibility for the NBC-HWC credential requires completion of an NBHWC-approved training program, practical coaching experience, skills assessment, national examination, and applicable education or qualifying work-experience requirements. These requirements reflect the substantial work undertaken by NBHWC to establish and maintain rigorous national standards for the profession and provide a standardized mechanism for independently verifying that NBC-HWCs possess the competencies necessary to furnish the CPT-defined HWC service.

NBHWC has systems in place to support and ensure timely education, assessment, and credentialing of qualified HWC professionals throughout the United States. As noted previously, NBHWC collaborates with the National Board of Medical Examiners, a national leader in high-stakes health-professions assessment with extensive experience in physician examinations.

As one of the three credentialing organizations specifically identified by CMS in the proposed rule, NBHWC provides a national foundation for standardized education and individual certification in HWC. Because states generally do not license health and wellness coaches,

[3] Abu Dabrh, A.M., Reddy, K., Beech, B.M. and Moore, M., 2024. Health & wellness coaching services: Making the case for reimbursement. *American Journal of Lifestyle Medicine*, p.15598276241266784.

national competency-based certification provides an essential mechanism for independently verifying qualifications. Individuals may or may not also hold other professional licenses or credentials, *but an additional healthcare license or degree should not be required to demonstrate competency in the CPT-defined HWC service*.

Maintaining rigorous individual competency standards is particularly important as Medicare establishes national payment levels. Payment policy should promote access while ensuring that beneficiaries receive the defined HWC service from individuals whose competency to furnish that service has been independently assessed and validated. Under the Medicare framework NBHWC recommends, appropriately credentialed HWC professionals should be permitted to furnish these services as auxiliary personnel under the general supervision of the billing practitioner, regardless of whether they also hold another healthcare license or credential.

Conversely, the use of coaching techniques within another professional encounter should not, by itself, establish that the separately identifiable CPT-defined HWC service has been furnished; individuals billing HWC services should independently meet the applicable HWC competency and certification requirements. NBHWC stands ready to support timely and responsible implementation for Medicare beneficiaries and participating providers.

V. CMS should clarify that CPT codes 0591T, 0592T, and 0593T are subject to general supervision—not direct supervision—by the billing practitioner. Health and wellness coaching is routinely provided under general supervision throughout the United States, and the published evidence and extensive practical experience do not identify a clinical rationale for requiring direct supervision. A direct supervision requirement would be inconsistent with longstanding and common practice, and would create an unnecessary barrier to care, especially in rural and other underserved populations where physician resources are thinly stretched.

NBHWC recommends that HWC be furnished by appropriately credentialed auxiliary personnel incident to a billing practitioner under general supervision, consistent with Medicare's general-supervision framework for designated care management services (42 CFR § 410.26). This framework would preserve appropriate practitioner oversight while enabling longitudinal, time-based behavior-change services without requiring the billing practitioner to be immediately available during each coaching encounter. Requiring direct supervision would add unnecessary staffing, scheduling, and administrative burden, constrain telehealth and community-based delivery, and disproportionately limit implementation in rural and other resource-constrained settings without a corresponding clinical rationale. Whether engaged

through a contractual relationship or an employment agreement, health and wellness coaches should be meaningfully integrated into the broader care team through clear communication, appropriate practitioner oversight, and established workflows that support general supervision in practice.

We encourage CMS to resolve the apparent internal inconsistency in the proposed rule regarding the applicable level of supervision. CMS's discussion of the valuation of these services recognizes their similarity to Chronic Care Management and describes them as being performed under general supervision, while other language in the proposal could be read to require direct supervision. The final rule should state unambiguously that general supervision applies to CPT codes 0591T, 0592T, and 0593T.

Health and wellness coaching is routinely furnished under general-supervision models, including within large healthcare systems, and the available evidence and extensive practical experience do not identify a clinical rationale for requiring direct supervision. A direct-supervision requirement would be inconsistent with established delivery models and would create an unnecessary barrier to care, especially in rural and other underserved populations where practitioner resources are limited.

CMS specifically states that individuals employed by community-based organizations may operate under the general supervision of the billing practitioner, provided the applicable training and certification requirements are met. This further supports a consistent general-supervision standard for CPT codes 0591T, 0592T, and 0593T across all permitted delivery arrangements.

VI. CMS should finalize its proposal to adopt the CPT prefatory language for CPT codes 0591T, 0592T, and 0593T without revision.

CMS proposed to adopt the following language from the CPT prefatory language:

> "Health and wellbeing coaching is a patient-centered approach wherein patients determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The health and well-being coach is qualified to perform health and wellbeing coaching by education, training, national examination and, when applicable, licensure/regulation, and has completed a

> training program in health and well-being coaching whose content meets standards established by an applicable national credentialing organization. The training includes behavioral change theory, motivational strategies, communication techniques, health education and promotion theories, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and wellbeing."

This language accurately captures the key aspects of successful health and wellness coaching as supported by the published, peer-reviewed clinical literature, as well as reflecting the importance of robust education, training, and national examinations to support consistent, high-quality delivery of HWC services. Further, this language supports the conclusion that coaching is an evidence-based, proactive, and structured healthcare service grounded in behavior-change science, health promotion and education, motivational strategies, and skilled communication, and delivered through validated professional competencies.

We particularly support preservation of the patient-centered and self-determined nature of the service, together with the requirement that individuals furnishing HWC possess education and training meeting standards established by an applicable national credentialing organization. These elements distinguish HWC as a defined behavior-change service while preserving fidelity to the established CPT framework.

VII. **CMS should preserve telehealth access for health and wellness coaching services.**

We support continued Medicare access to HWC through telehealth, including synchronous audiovisual and, where permitted by Medicare policy, audio-only delivery. Medicare has included the Category III HWC CPT codes on the Telehealth List since 2024, and health systems, including VHA, routinely deliver coaching virtually to expand access for rural, mobility-limited, and other underserved beneficiaries.

* * * * *

Taken together, finalizing national payment, preserving the established HWC service definition, clarifying general supervision, ensuring appropriate time-based valuation, maintaining rigorous individual competency and credentialing standards, and establishing a durable coding pathway would provide Medicare beneficiaries meaningful access to HWC as a distinct, competency-based service supporting lifestyle change and whole-person care, while preserving the quality and accountability necessary for responsible implementation.

National Board for
Health and Wellness Coaching

As a national credentialing organization that has played a central role in creating and advancing professional standards, competency-based certification, evidence development, and healthcare integration for HWC, the National Board for Health and Wellness Coaching (NBHWC) remains committed to supporting CMS in advancing a responsible and sustainable Medicare pathway for HWC that promotes value, beneficiary engagement, care coordination, and accountability.

We look forward to collaborating with you and your colleagues at CMS in serving the needs of Medicare beneficiaries. Please do not hesitate to contact me at BoDchair@nbhwc.org or (866) 535-7929 with any questions.

Sincerely,



Moain Abu Dabrh, MBBCh, MS, NBC-HWC
Chair, Board of Directors
National Board for Health and Wellness Coaching

Table 1: Selected Evidence on Certified Health and Wellness Coaches from NBHWC-Approved Programs Across Healthcare Populations and Outcomes

Study ID	Design	Setting; condition; N	Key finding
Seal 2026	RCT	6 VA systems; adult veterans with moderate-to-severe chronic pain; 764	*Pain management:* BPI pain interference improved from 6.55 to 4.91, significantly greater than CBT (−0.58; P=.02) and usual care (−0.77; P=.002) at 12 months
Wolever 2022	RCT	Military primary care; adults at elevated CHD/T2D risk; 200	*Physical activity:* Increased moderate-to-intense activity at 6 and 12 months in the per-protocol analyses. Weight management: Higher-T2D-risk participants lost 2.2 kg more at 12 months.
Lee 2025	RCT (secondary analysis)	Military primary care; adults at high CHD/T2D risk; 200	More favorable progression from contemplation and preparation to action across four health behaviors
Mielenz et al., 2020	RCT	5 public-housing communities; older adults with ≥2 chronic conditions; 121	*Physical function:* PROMIS physical function improved 2.6 vs 0.6 points over 6 months (2.0-point greater improvement; p=.03).
Hildebrandt 2020	RCT	Integrated health system; adults with binge-eating disorder or bulimia nervosa; 225	*Eating disorder remission:* Binge-eating remission at 52 weeks was 56.7% vs 30.0% with standard care (NNT=3.74). *Compensatory behaviors:* Remission was 76.3% vs 56.8%.
Myers 2024	Qualitative study nested within an RCT	Rural communities; adults at elevated Alzheimer/cognitive-decline risk; 80	*Behavior change/acceptability:* Participants valued goal setting, lifestyle-change strategies, self-awareness, and coach support
Breneman 2026	Single-arm pilot trial	VA tertiary care; Veterans with complex chronic conditions; 48	*Healthy lifestyle habits:* Significant improvements in physical health-related quality of life, sleep quality, anxiety, depression, and mindfulness. *Goal attainment/adherence:* 60.6% of SMART goals achieved and 88.0% adherence.
Mirsky 2026	Retrospective propensity-matched cohort study	Mass General primary care; hypertension virtual SMA participants; 400	*Blood pressure control***:** Among patients with baseline BP >130/80 mmHg, systolic BP decreased 8.7 vs 3.9 mmHg; 33% vs 16% achieved BP <130/80 mmHg

McGill 2018	Mixed-methods program evaluation	Population-based telephone lifestyle service; adults seeking weight/lifestyle change; 59	*Engagement/behavior support:* Participants most valued coach support, accountability, rapport, and professionalism; coaching was perceived to support motivation and goal attainment.
Abu Dabrh 2025	Mixed-methods single-arm pilot trial	Tertiary specialty nephrology; polycystic kidney disease (ADPKD); 14 patients and caregivers	*Care burden/self-efficacy:* Patient treatment burden decreased initially but was near baseline by 6 months; caregiver self-efficacy increased (30.1→33.0). *Behavior change:* improved routines, adherence strategies, goal setting, and care engagement.
Rose 2025	Longitudinal pre-post program evaluation with randomized maintenance phase	University and hospital employees; 50	*Physical/mental health:* PROMIS physical health improved +3.0 points and mental health +2.3 points at 12 weeks. Physical-health improvement remained significant through 24 weeks; mental-health improvement did not remain significant at the later follow-up assessments. *Stress:* decreased 2.6 points at 12 weeks; gains persisted up to 24 weeks.
Kennedy 2025	Pre/post pilot study	Academic medical center; adults; 28	*Wellbeing:* WHO-5 improved 53.3→64.3 at 6 months (+11.4 points; $p<.01$); 52% achieved a clinically meaningful ≥10-point improvement.
Abu Dabrh 2023	Pre/post pilot study	Academic center primary care; adults with overweight and additional cardiometabolic risk factors; 37	*Weight:* BMI decreased 1.63 kg/m² at 12 weeks and 1.51 kg/m² at 6 months *cardiometabolic risk:* LDL decreased 17.8 mg/dL at 12 weeks and 13.4 mg/dL at 6 months (all $p<.001$). *Self-regulation:* Energy/fatigue, self-regard, decision-making, impulse control, and stress management also improved at 6 months.

Hackshaw 2016	Single-arm pilot trial	Academic rheumatology; women with primary fibromyalgia; 9	*Pain/fibromyalgia impact:* FIQR improved 35% and BPI pain interference 44% at 12 months. *Healthcare utilization:* Total encounters declined 86% and rheumatology encounters 78% in the year after coaching
Denneson 2023	Qualitative implementation study	5 VA sites; interdisciplinary chronic-pain teams; 22	*Care integration:* Stakeholders reported greater personalization, coordination, and patient progress toward goals; successful implementation required role clarity and ongoing team communication.

Note: Included studies represent diverse HWC service models and implementation pathways, including services delivered by certified health and wellness coaches and, in some programs, supervised HWC trainees completing formal training and certification requirements.

Table 1 References

- Seal KH, Morasco BJ, Martin AM, et al. The Veterans Affairs' Whole Health Approach for Chronic Pain Management: The wHOPE Randomized Clinical Trial. *JAMA.* 2026;335(20):1774–1786. doi:10.1001/jama.2026.5006
- Wolever RQ, Yang Q, Maldonado CJ, Armitage NH, Musty MD, Kraus WE, Chang J, Ginsburg GS, Vorderstrasse AA. Health coaching and genetic risk testing in primary care: Randomized controlled trial. Health Psychol. 2022 Oct;41(10):719-732. doi: 10.1037/hea0001183. Epub 2022 May 19. PMID: 35587890.
- Lee C, Yang Q, Vorderstrasse A, Wolever RQ. Health Coaching Impacts Stage-Specific Transitions in Multiple Health Behaviors for Patients at High Risk for Coronary Heart Disease and Type 2 Diabetes: A Multigroup Latent Transition Analysis. J Cardiovasc Nurs. 2025 Sep-Oct 01;40(5):E220-E230. doi: 10.1097/JCN.0000000000001154. Epub 2024 Oct 24. PMID: 39454076.
- Mielenz TJ, Tracy M, Jia H, Durbin LL, Allegrante JP, Arniella G, Sorensen JA. Creation of the Person-Centered Wellness Home in Older Adults. Innov Aging. 2020 Jan 22;4(2):igz055. doi: 10.1093/geroni/igz055. Erratum in: Innov Aging. 2020 Mar 18;4(1):igaa005. doi: 10.1093/geroni/igaa005. PMID: 31989045; PMCID: PMC6974576.
- Hildebrandt T, Michaeledes A, Mayhew M, Greif R, Sysko R, Toro-Ramos T, DeBar L. Randomized Controlled Trial Comparing Health Coach-Delivered Smartphone-Guided Self-Help With Standard Care for Adults With Binge Eating. Am J Psychiatry. 2020 Feb 1;177(2):134-142. doi: 10.1176/appi.ajp.2019.19020184. PMID: 32008396.

- Myers JR, Bryk KN, Madero EN, McFarlane J, Campitelli A, Gills J, Jones M, Paulson S, Gray M, Glenn JM. Initial Perspectives From Rural-Residing Adults on a Digital Cognitive Health Coaching Intervention: Exploratory Qualitative Analysis. JMIR Form Res. 2024 Jul 22;8:e51400. doi: 10.2196/51400. PMID: 39038282; PMCID: PMC11301112.
- Breneman CB, Summers AC, McCullers R, Jachimowicz W, Allen N, Chester J, Tschida S, Proctor L, Bayley PJ, Barrett J, Reinhard MJ, Costanzo M. Assessing the Feasibility and Acceptability of VA Whole Health Coaching Among Veterans With Complex Health Care Needs-A Pilot Study. Am J Lifestyle Med. 2026 Jul 2:15598276261460841. doi: 10.1177/15598276261460841. Epub ahead of print. PMID: 42404660; PMCID: PMC13331788.
- Mirsky J, Sung M, Choudhry NK, Crum KL, Rahmoune A, Hanken KE, Lauffenburger JC, Haff N. Delivering Lifestyle Interventions for Chronic Disease Care Sustainably and at Scale through Virtual Shared Medical Appointments in Primary Care. NEJM Catal Innov Care Deliv. 2026 Jun;7(6):CAT250284. doi: 10.1056/CAT.25.0284. Epub 2026 May 20. PMID: 42418614.
- McGill B, O'Hara BJ, Phongsavan P. Participant perspectives of a 6-month telephone-based lifestyle coaching program. Public Health Res Pract. 2018 Jun 14;28(2):27451705. doi: 10.17061/phrp27451705. PMID: 29925086.
- Abu Dabrh AM, Borghol AH, Alkhatib B, Paul S, Li Z, Lehman WM, Mao MA, Hickson L, Chebib FT. Health and Wellness Coaching to Reduce Care Burden in Autosomal Dominant Polycystic Kidney Disease Care: A Mixed-Methods Pilot Study of BeWell360-PKD Dyadic Model. Kidney360. 2026 Mar 1;7(3):591-601. doi: 10.34067/KID.0000000950. Epub 2025 Aug 21. PMID: 40839418; PMCID: PMC13065154.
- Rose GL, Smith AM, Mossburg J, Westervelt K. Impact of an Employee Health and Wellness Coaching Program on Self-Reported Stress, Physical Health, and Mental Health in Hospital and University Employees. Glob Adv Integr Med Health. 2025 Jul 29;14:27536130251363933. doi: 10.1177/27536130251363933. PMID: 40756628; PMCID: PMC12314245.
- Kennedy S, Carmack S, Li L, Lin FC, Hatch JE, Chan K, Tolleson-Rinehart S, Noah TL. Coaching Pediatricians for Wellbeing: A Pilot Feasibility and Acceptability Study. Acad Pediatr. 2025 Mar;25(2):102586. doi: 10.1016/j.acap.2024.09.010. Epub 2024 Oct 1. PMID: 39362630.
- Abu Dabrh AM, Haga CB, Conrad J, Perlman AI, Allyse MA, Albertie ML, Martinez-Heath M, Ball CT, Willis FB. Nutrition and Emotional Health Education: The Use of Emotional Intelligence and a Plant-Based Diet to Reduce Cardiometabolic Risk. Glob Adv Integr Med Health. 2023 Nov 17;12:27536130231215014. doi: 10.1177/27536130231215014. PMID: 38026440; PMCID: PMC10656810.
- Hackshaw KV, Plans-Pujolras M, Rodriguez-Saona LE, Moore MA, Jackson EK, Sforzo GA, Buffington CA. A pilot study of health and wellness coaching for fibromyalgia. BMC Musculoskelet Disord. 2016 Nov 8;17(1):457. doi: 10.1186/s12891-016-1316-0. PMID: 27821160; PMCID: PMC5100173.
- Denneson LM, Purcell N, McGrath SL, Abadjian LR, Becker WC, Seal KH. Integration of Health Coaches in a Whole Health Team Model of Chronic Pain Care: a Qualitative Study. J Gen Intern Med. 2023 Dec;38(16):3574-3580. doi: 10.1007/s11606-023-08317-x. Epub 2023 Jul 18. PMID: 37464147; PMCID: PMC10713909.