

Opportunities for Whole Health Promotion: Research and Examples



The movement for health equity demands that health care move beyond exclusively clinical markers of wellbeing. Studies suggest that social determinants of health—including socioeconomic conditions, the environment and health behaviors—can account for 80 percent or more of variations in people’s health, while clinical care impacts only 20 percent of health outcomes.¹

Whole Health Includes:



These social determinants are often outgrowths of structural discrimination. Promoting whole health thus requires providers to consider patients' mental, behavioral, environmental and social wellness in addition to their physical health. Addressing health inequities, in everything from birth outcomes to mental health to oral health to diabetes, requires looking at a person in the full context of their lived experience. Federally funded Patient-Centered Outcomes Research (PCORI) highlights the need for health interventions beyond clinical care to empower people to lead their healthiest lives.

This publication explores three PCORI-funded studies that propose new frameworks for advancing whole health. It also identifies current programs across the United States that offer examples of interventions suggested by those studies. We provide an overview of research-backed solutions to whole health challenges and highlight how those solutions can work in action.

Intimate Partner Violence: “Is it possible for safety to occur in the absence of health?”

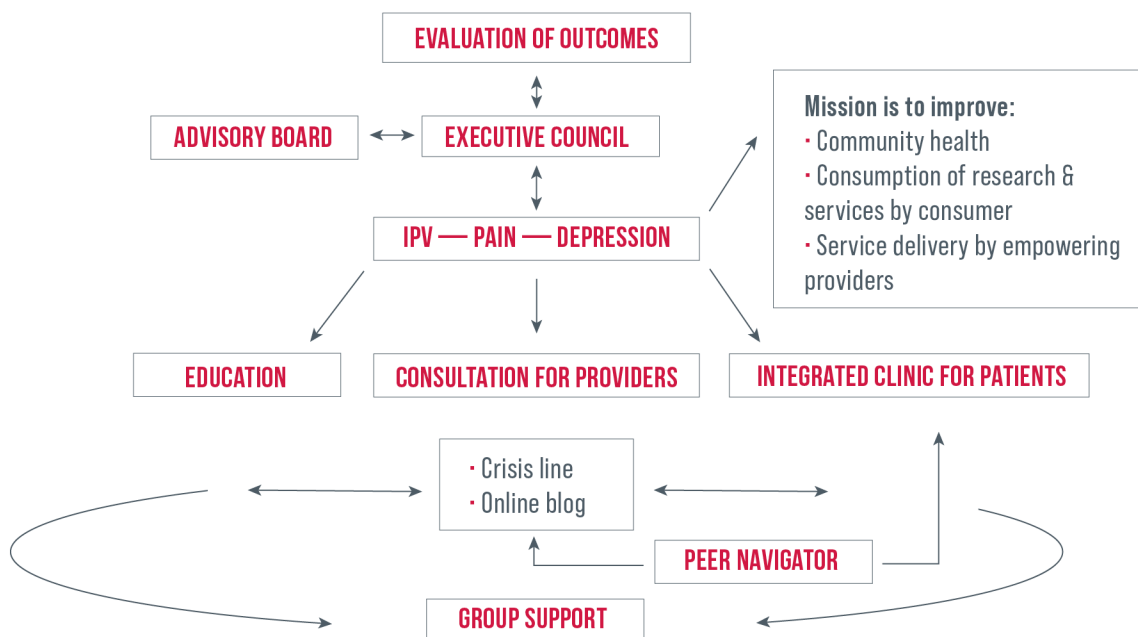
THE STUDY: Development of an Innovative Treatment Paradigm for Intimate Partner Violence Victims With Depression and Pain Using Community-Based Participatory Research²

WHY: Intimate partner violence (IPV) can have a variety of adverse health effects on survivors. This study looks at depression and chronic pain as two “particularly prevalent co-occurring problems for survivors,” but notes that clinicians and other providers may be unaware of IPV.

HOW: Community-based participatory research engaged five focus groups of IPV survivors and a community advisory board of survivors, advocates and providers.

FINDINGS: Survivors feel best supported by a combination of formal medical and behavioral health services, education regarding informal coping strategies and spirituality. A comprehensive IPV intervention requires education for survivors, providers and the general community about the complex health issues associated with IPV and the available resources to address it; an integrated consultation service for providers; and a trauma-informed, accessible clinic. Figure 1 depicts the complex relationships that can support effective IPV interventions.

Figure 1



*Modified from a figure in the published study: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6944275/figure/F2/>

IN PRACTICE:

States and advocates can:

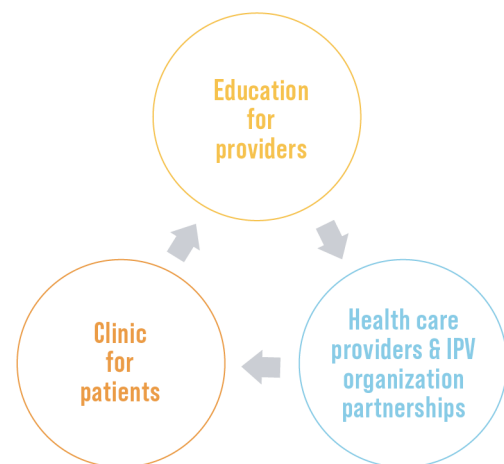
- 1. Ensure that traditional Medicaid, as well as Medicaid expansion programs, cover IPV screening.** The Affordable Care Act requires coverage for this screening in Medicaid expansion programs and in health plans offered in the marketplace. In addition, states should opt to cover the screening in their traditional Medicaid programs.³
- 2. Disseminate information about service codes that providers can use to bill domestic violence screening.** Current Procedural Terminology codes (that is, CPT codes, used to bill medical services) for this screening are not standard across states.⁴ State Medicaid agencies should issue guidance to Medicaid providers about service codes that they can use.
- 3. Provide consumer and navigator outreach about the right to special enrollment periods in marketplace plans and the right to IPV screening without cost-sharing.** Victims of domestic abuse or spousal abandonment, and their dependents, have the right to enroll in a marketplace plan separate from that of their abuser. They can do so outside of normal open enrollment periods.⁵
- 4. Cultivate relationships among primary care providers, primary care associations and state and tribal domestic violence coalitions.** The National Coalition Against Domestic Violence lists state coalitions at <https://ncadv.org/state-coalitions> and provides resources and links for Indian and Alaska Native organizations at http://www.ncdsv.org/ncd_linksnativetribal.html.

Example: Domestic Violence Health Care Partnership Project (California)

The anti-IPV advocacy organization Futures Without Violence partnered with the Blue Shield of California Foundation to pair primary care clinics and local domestic violence organizations into integrated IPV service teams in 19 cities.⁶ California plans to scale up similar interventions.

An evaluation found that healthcare providers who participated in the partnership were more likely to screen for interpersonal violence and discuss it with their patients, patients were more likely to report it and patients experiencing violence had increased understanding of its effect on personal health. Participating health care providers and domestic violence advocates benefited from the collaboration.⁷

Caring for Patients Who Experience Interpartner Violence



Addressing material hardship to help safeguard mental health

THE STUDY: Material Hardship and Mental Health Symptoms among a Predominantly Low-Income Sample of Pregnant Women Seeking Prenatal Care⁸

WHY: Poor mental health during pregnancy has long been associated with adverse birth outcomes, such as low birth weight, and lower post-pregnancy health of both the mother* and child. This study explored possible connections between material hardship, defined as difficulties in meeting basic daily needs such as food, housing, or transportation, and pregnant women's mental health. The findings suggest that healthcare providers should adopt models of care that address the social determinants of health in order to prevent and more effectively diagnose and treat some mental health conditions.

HOW: Researchers interviewed pregnant women at three community-based OB/GYN practices in upstate New York that primarily served financially disadvantaged patients. Participants were asked to self-report mental health symptoms and the extent to which they were experiencing material hardship.

FINDINGS: Interview responses revealed that the co-occurrence of material hardship, depression and anxiety was common among low-income pregnant women; over half of study participants reported material hardship, and almost one in four reported anxiety and/or depression. The study also revealed that depression and anxiety were uniquely associated with lower income and greater material hardship, even after controlling for certain other factors.⁹ People of color also experienced higher levels of material hardship compared to other groups. The most common unmet material needs included transportation to and from medical appointments, food and nutrition, clothing and stable housing. These findings indicate that pregnant women in low-income areas are often unable to meet basic daily needs and therefore may be at higher risk for depression and anxiety.

IN PRACTICE: Eliminate barriers between health care services and social and economic service delivery

Healthcare providers should redesign health systems to consider and address the underlying social and economic needs of families, including parents and children. State Medicaid agencies and provider regulators should identify local opportunities to build redesign strategies at the state level. For example:

- » Bring medical and behavioral health services physically into community-based organizations that provide social services on a part- or full-time basis instead of simply referring families to such services.

*This study specifically referred to mothers, though we anticipate that findings would be similar for all pregnant people.

- » Incorporate social workers and community health workers into healthcare teams that serve parents and children.
- » Offer support groups to families, including groups that focus on medical care, behavioral health and education. For example, offer recovery groups and parenting groups.
- » Better link Medicaid to other benefit systems.
- » Build regional, state and local information exchange systems to facilitate communication and referrals between health care providers and social service organizations.
- » Use Medicaid waivers to help finance a broader array of services, including rent and food assistance.
- » Collect data to evaluate the long-term effects of these interventions.

The White House Blueprint for Addressing the Maternal Health Crisis, published in June 2022, calls for a number of changes to respond to the maternal health crisis.¹⁰ These include providing more holistic care and social service connections to pregnant and postpartum people at Veterans' Health Administration facilities; streamlining enrollment systems to foster better linkages among Medicaid, housing assistance, financial assistance and food assistance; replacing lead pipes; expanding maternal mental health access; training maternal health providers to address implicit bias and screen for social determinants of health; identifying and addressing effects of climate change on maternal health; and improving awareness of workplace protections for pregnant and postpartum women.¹¹

Additional Designs for Consideration: Several states and health systems have piloted innovations in integrated family care over the last decade that could be scaled up. [This resource](#) provides some examples¹²:

- » **New York City Health and Hospital Systems** brought medical services into community-based facilities, such as Health Start programs, that were already providing social services to families, allowing for bidirectional referrals. Patients can use their mobile phones to note their health and social support needs prior to primary care visits. Records shared among a primary care provider, mental health partner and social services provider help all of them to monitor service delivery.
- » In a **Michigan** program, an infant mental health therapist participates in postpartum visits at OB-GYN offices and follows up with home visits if needed. Public health and foundation dollars supplement Medicaid to support this intervention.

- » In **New Hampshire**, strengths-based recovery support groups have helped pregnant and postpartum people sustain their recoveries from substance use disorders and to parent and obtain supports for their children. To date, the community health workers and social workers that are part of the pediatric teams are funded by grants.
- » **New York’s 1115 Medicaid Waiver** supports behavioral health care collaboratives— clinically integrated networks of health and social service providers delivering family-focused mental health, substance use, primary care, care management and social services—using a value-based payment arrangement.

In **Oregon**, a newly announced Medicaid waiver program will allow individuals who rely on Medicaid for health care to receive financial support through their Medicaid plan for “health-related social needs.”¹³ For example, Oregon will offer a specific package of transitional rental and food assistance using Medicaid dollars. Starting in 2024, this program will be available to certain at-risk populations, including youth in foster care, people who are homeless or at risk of homelessness and low-income older adults.

Further, **Oregon** streamlined its Medicaid enrollment process for children. Previously, families were required to re-enroll their children into Medicaid annually, creating a barrier and causing some families to lose health coverage for their children. Now families will be able to keep their children continuously enrolled in Medicaid up to age 6 and all other children and adults for two-year enrollment periods. This change will help protect children from experiencing any gaps in coverage.

As part of a broader Medicaid waiver program focused on social determinants of health, **North Carolina** and **Arizona** are taking vendor-based information technology approaches to health care provider referrals to community-based organizations. North Carolina has contracted to create [a statewide utility](#) for community-based organization referrals, aiming to “enable health care and human service providers to send and receive secure electronic referrals, seamlessly communicate in real-time, securely share client information and track outcomes.”¹⁴ Arizona’s [related system](#) for referrals is built on the chassis of its state health information exchange.¹⁵ Both states emphasize that their contractors close the loop on referrals and follow-ups to maximize access to social determinants of health–related services.

Address Hardship and Health



LINK HEALTH +
SOCIAL SERVICES



BRING HEALTH CARE
INTO CBOs



MAKE CHWs AND
SOCIAL WORKERS
PART OF CARE TEAMS

Helping parent-child dyads address mental and physical health

THE STUDY: Fostering Activation Among Latino Parents of Children With Mental Health Needs: A Randomized Control Trial(RCT)¹⁶

WHY: Individuals with a sense of activation (defined as “self-efficacy in self-management of chronic disease, knowing when and where to go for help, and getting one’s needs met in a health care visit”) experience improved health outcomes.¹⁷ A number of studies show that Latino children with mental health needs are only half as likely to use services as children in white non-Latino families. Further, Latino families are more likely to report problems getting services or dissatisfaction with care.¹⁸ Therefore, researchers explored how to support Latino parents’ activation on behalf of their children.

HOW: Parents who self-identify as Latino were recruited from a Spanish-language mental health clinic in a medium-sized city in North Carolina. Once enrolled, they were assigned to participate in either a psychoeducational program or a nondirected social support group. Both programs focused on helping participants’ children access mental healthcare. The psychoeducational intervention, whose effect researchers wanted to test, was called MePrEPA—metas, preguntar, escuchar, preguntar para aclarar (goals, questioning, listening, questioning to clarify). In four evening sessions, parents learned and practiced skills to understand their children’s mental health needs, work with providers, activate and work with schools.

FINDINGS: As measured through a survey, parents who participated in the MePrEPA group saw a greater increase in their activation (33 percent) after three months than parents who took part in the social support group. The skills of members of the MePrEPA group in working with their children’s school systems also improved. The positive impact of MePrEPA on parental activation was greater for children covered by Medicaid and those who were using therapy for the first time.

IN PRACTICE: Ways that states can strengthen parent-child dyads

1. **Offer** linguistically and culturally appropriate educational and behavioral health interventions with parents.
2. **Implement** dyadic models of care for families.
3. **Braid** Medicaid funding with state and federal mental health and public health funding to significantly scale up parent-facing and dyadic programs.
4. **Evaluate** what works.

Medi-Cal, **California**'s Medicaid healthcare program, will begin implement its its Strategy to Support Health and Opportunity for Children and Families in January 2023. This new initiative will increase coverage and infrastructure for dyadic models of care that integrate behavioral health, pediatric care and other family services for children aged zero to five years.¹⁹ At medical visits, the parent (or caregiver) and child dyad will receive screening, referrals and navigational help to address behavioral health problems, interpersonal safety, substance misuse, food insecurity and housing instability.²⁰ Further, children of all ages and parents with a broad range of risk factors can receive family therapy with no prerequisite mental health diagnosis.²¹ Even if only the child has Medi-Cal coverage, both parent and child can get care. About three-quarters of Latino children in California are enrolled in Medi-Cal, and linguistically and culturally appropriate care and outreach are essential to the program's success. Community health workers, *promotoras*, peers, and doulas all can play roles in providing culturally appropriate care rooted in lived experience, and they will be part of California's community-based care teams.²² Additionally, the California Department of Public Health will launch culturally specific public education and awareness campaigns regarding children and youth behavioral health.²³

Project Training and Education for the Enhancement of Children's Health (TEACH) is a **New York**-based nonprofit funded by the New York State Office of Mental Health. Its mission is to "strengthen and support the ability of New York's Maternal Health and Pediatric Primary Care Providers ... to deliver care to children and families who experience mild-to-moderate mental health concerns." Maternal health and pediatric clinicians can consult by phone with a child and adolescent psychiatrist, find referrals and supportive services for their patients, obtain training and use educational materials. In addition, Project TEACH disseminates educational materials for parents seeking care for their children. The topics of these educational videos range from "What to Discuss During Your Children's Primary Care Visit" to "How to Support Your Child Diagnosed with ADHD." They are available in English, Spanish, Bengali, Haitian Creole, Korean, Russian and Simplified Chinese.²⁴ The trainings, accessible online at no cost, suggest that the type of information communicated through MePrEPA, which helped parents support their children's mental health, could be disseminated widely to clinicians, parents and caregivers as part of a formal strategy.

In **North Carolina**, El Futuro, the clinic that piloted MePrEPA, encourages community behavioral health organizations serving Latinos to participate in patient-centered research projects to continue to develop and disseminate evidence about what works. El Futuro's website presents a toolkit for community-based organizations to engage in research.²⁵ Such research will be crucial to further advancing whole health for all.



Information that helps parents support their children's mental health could be disseminated widely to clinicians, parents and caregivers as part of a formal strategy.

Conclusion

Research demonstrates the effectiveness of integrated care that empowers individuals and families to address mental, behavioral, environmental and social wellness along with their physical and oral health. Existing interventions that promote whole health care can serve as models for state policymakers and advocates.

Endnotes

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- ⁹ The study controlled for age, race/ethnicity, relationship status, and number of children at home.
- ¹⁰ “White House Blueprint For Addressing The Maternal Health Crisis.” 2022. <https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf>.
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- ¹² Brundage, Suzanne, et al. n.d. “Profiles in Integrated Family Care.” https://uhfnyc.org/media/filer_public/e0/8b/e08ba598-a063-4f22-a5ce-2226db452f26/report_profiles_in_integrated_family_care.pdf.
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- ²⁰ Cal. Welf. and Inst. Code § 14132.755
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About the Project

This paper was funded through a Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award (EADI #20949).

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