EDITORIAL

Collaborative Family Health Care, Civil Rights, and Social Determinants of Health

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Social and economic disadvantage and civil rights infringement, worsens overall health (Adler, Glymour, & Fielding, 2016; McGowan, Lee, Meneses, Perkins, & Youdelman, 2016; Teitelbaum, 2005). While addressing these challenges is not new, there is reason to believe that the administration of Donald Trump and a republican majority in congress will exacerbate these challenges and their effects. Speaker Ryan has promised to Repeal the Affordable Care Act and defund Planned Parenthood. The Human Rights Watch, in its summary of events in 2016 in the United States stated:

The election of Donald Trump as president in November 2016 capped a campaign marked by misogynistic, xenophobic, and racist rhetoric and Trump’s embrace of policies that would cause tremendous harm to vulnerable communities, contravene the United States’ core human rights obligations, or both. (Human Rights Watch, 2017)

How can collaborative family health care (CFHC) practitioners and our field help? We pondered this question and also asked a selection of leaders in the field. We will first share ideas about the potential of CFHC to make a difference in daily interactions with patients. Next, we identify key areas of risk and vulnerability. Finally, using the contributions of respected colleagues, we propose a partial agenda for CFHC clinicians and the field.

Why does collaboration between primary care and behavioral health enhance our capacity to help patients and families affected by civil rights infringement and social disadvantage? We believe the reason lies not in easily measured events or outcomes, but rather in the deep listening and caring that is a natural byproduct of effective collaboration. When health care clinicians share with one another a commitment to care, patients and families are seen more for who they are in the context of their lives. We can more easily recognize the influence of civil rights infringement and social factors, rather than become annoyed by them, or worse, participate in perpetuating them. This understanding of patient experience is an important example of what Dr. Egnew describes in this issue as the perennial philosophy of integrated care—the relief of suffering (Egnew, 2017).

A dual optic (Bloch, 1988) team employs a pyramid of skills to explore and incorporate the patient and family world view. The foundation of the pyramid includes curiosity, empathy, and validation. The upper layers include treating patients and families in ethical ways that respect their values, involving them in shared decision making, promoting their involvement in their own health care, and
tailoring support to match the complexity of their needs. The outcome of collaboration is greater than the sum of disciplines. Effective collaborative relationships create shared accountability and intrinsic reward, reinforcing and challenging each of us to go further in understanding, caring, and staying engaged.

What are high risk, vulnerable areas of civil rights infringement and social determinants of health that collaborative practice teams may be more likely to detect and address?

- **Racism:** The presence and effects of racism in health care are well documented (Hardeman, Medina, & Kozhimannil, 2016).
- **Poverty:** Poverty significantly increases the risk for social and behavioral health problems and chronic medical illness (Lynch, Kaplan, & Shema, 1997).
- **Ethnic bias:** When people fear that their basic rights are threatened due to their immigration status or ethnic origin, they may be reluctant to engage in health care and have less ability to manage chronic conditions (Smith, 2005).
- **Sexual orientation:** LGBTQ U.S. citizens and immigrants have important health care needs that if missed, can severely compromise health-related quality of life (Gorman, Denney, Dowdy, & Medeiros, 2015; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006).
- **Reproductive agency:** The inability of a woman to gain access to contraception and termination of pregnancy services has profound impact on social, psychological, and biomedical well-being (National Women’s Law Center, 2017).
- **Access to health care:** Repealing the Affordable Care Act may increase the numbers of uninsured. People who are inadequately insured are less likely to seek care for acute illness, chronic illness, serious problems or preventive care (Baker, Shapiro, & Schur, 2000; Karaca-Mandic, Jena, & Ross, 2017; Weissman, Stern, Fielding, & Epstein, 1991).

What agenda items might the CFHC field and its clinicians embrace? Below we share the contributions from others in our field. The collaborative relationship enhances our opportunity to explore bias, create strategies for dealing with inequity and continue building health care designs that maximize quality of care. We also hasten to draw your attention to the presidential column in this issue where Dr. Runyan examines CFHC if and when the Affordable Care Act is dismantled (Runyan, 2017).

**Support Patient Autonomy**

Seek out research on collaborative models that address not only medical/behavioral needs and social determinants, but also support patient autonomy, growth/competence and human connection in the process of giving patients and families the tools to improve lifestyles, better manage chronic medical and behavioral conditions. (Kevin Fiscella, MD, MPH, personal communication, January 3, 2017)

"[We should be] more active in advocating for what we believe is a right for everyone—democrat or republican, rich or poor, immigrant or native American . . .” (Susan McDaniel, PhD, personal communication, January 3, 2017).

**Be Aware of Our own Political Bias**

“Be more willing to speak with Trump-supporters to try and understand what we don’t. Perhaps there are some in our membership who could help with that” (Susan McDaniel, PhD, personal communication, January 3, 2017).

“Collaborative family healthcare (CFHC) is both a red and blue argument—the science is the same” (Ben Miller, PsyD., personal communication, January 3, 2017).
CFHC can make sure to appeal to what already matters to people on both sides of the political divide. That means actually finding out what matters to both sides and then clearly articulating how CFHC specifically appeals to . . . those interests. . . . And not to forget the possibility that something about CFHC bothers people on one or both sides. If the field doesn’t understand this kind of thing, it won’t be effective in the social and policy discourse. (CJ Peek, PhD, personal communication, January 3, 2017)

Include “Family” in Health Care

“CFHC ought to articulate a vision of ‘family’ that is inclusive in terms of issues of gender, sexuality, marital status, and racial/ethnic dimensions. This commitment should be backed up with a description of relevant competencies for practice” (Daniel Mullin, PsyD, MPH, personal communication, January 3, 2017).

We need a national healthy families initiative that recognizes the importance of social determinants, behavioral and medical health to healthy families. The connection between healthy families, healthy communities, and healthy countries is obvious to most on both sides, particularly if we separate family from religious overtones. . . . Strengthening families, including CFHC, might be one goal that our deeply divided country could eventually unite around. (Kevin Fiscella, MD, MPH, personal communication, January 5, 2017)

The system of the family (broadly defined) is becoming less of a focus in practice (electronic medical records don’t easily allow family data or connectedness—no ready way to include a quick snapshot such as a genogram; the emphasis on individual privacy, and the need to bill individuals with DSM or ICD codes). This moves one to think not systemically and on resilience, but reductionistically and about pathology. (George Saba, PhD, personal communication, January 5, 2017)

We need to train everyone in health care to recognize the important influence of family on health. From the newly married gay man with multiple chronic conditions, to the young teen pregnant with her first child, the effects of family relationships are profound. Training our family medicine residents to pay attention to these dynamics results in ‘aha’ moments for the clinical team, and helps patients feel more respected, ‘seen,’ and ‘known’ for who they are in their world. CFHC should develop training and competency expectations for all health care workers engaged in collaborative family care, regardless of role (Colleen T. Fogarty, MD, MSc).

Advocate and Participate in Policy Development

In this issue Wong, Green, Bazemore, and Miller help us learn “How to Write a Health Policy Brief” (Wong, Green, Bazemore, & Miller, 2016). This is an important tool in our shared work.

Pull together the various professional organizations, disciplinary academies and others working to integrate BH and family-oriented care around the basic purposes, language, and developmental steps to make CFHC more real and visible in the mainstream. This is to reduce unintended cacophony or differences in talking about the same things and values that arise across different organizations—which is an entirely natural thing, but interferes with making a policy or advocacy impact. (CJ Peek, PhD, personal communication, January 5, 2017 speaking on behalf of the APA Integrated Primary care alliance; http://www.apa.org/about/governance/president/alliance-meeting.aspx)

. . . the active ingredient in CFHC might be called an ‘anti-fragmentation’ compound—the net de-fragmenting effect of regarding health as including physical and mental, regarding health care organizations as being integrated that way, regarding clinicians as able to work the ‘dual optic,’ and regarding payment for total health and budgeting for both physical and mental health combined. Fragmented care ruins the patient experience, the provider experience, and the bottom line—a triple-sink of waste. We can just say that, but a concise way of bringing that evidence forward is needed—for evidence-based advocacy. (CJ Peek, PhD, personal communication, January 5, 2017)
Put the Patient and Family on the Team

I would like to see more studies of the impact on practices and on health systems of moving to clinical routines that actualize the role of patients on the team, the role we talk about and that policy makers put in the text of grants and contracts, but that we know very little about in practice. Others have written about the patient centered care plan in which the structure of the process ensures that the patient is an important author of the plan. People have been able to make sure the patient can read the notes about them, and use the notes as records of a relationship rather than records of only a treatment. Some practices commonly have their conversations about the patient in the flow of care in the room with the patient. (Alexander Blount, Ed.D., personal communication, January 6, 2017)

“Understanding that for the majority of folks they want to know what is going on and want to be an active player in their [health care] decisions” (William Gunn, PhD, personal communication, January 6, 2017).

We should also promote more of the involvement of patients, families, and community members in our clinical services, research projects, and in training. The perspective that someone brings from those positions really is both valuable and powerful as well as serving to keep me honest in my thinking and work. I think about care differently when I am a patient than as a clinician. (George Saba, PhD, personal communication, January 5, 2017)

Prevent and Treat Opioid Dependence

Place a much higher priority on preventing opioid dependence through behavioral management of pain and pushing for collaborative care for those who have become opioid dependent. More than 50,000 people died in 2015 from drug overdoses. We have been too slow to respond to this horrific epidemic. It is not only killing nearly as many Americans who died during the entire Vietnam War, but devastating communities and fomenting despair and rage. One of the key predictors of being a strong Trump supporter was residing in a community devastated by this epidemic. (Monnat, 2016; Kevin Fiscella, MD, MPH, personal communication, January 3, 2017)

Expand the Primary Care Team to Include Legal and Financial Assistance

Legal struggles involving immigration status, sexual identity, housing, employment, health insurance, and criminal prosecution can be disabling, and neither behavioral or biomedical intervention is sufficient. Including staff with legal, financial and social service expertise is essential for health care teams serving vulnerable populations. Adding these roles may also decrease risk of burnout for behavioral, biomedical and nursing clinicians (Marple, 2014; Larry Mauksch, M.Ed).

Summary

Perhaps the worst disease is the loss, or perceived loss, of autonomy that results from poverty, racism, ethnic prejudice, and the denial of sexual identity and reproductive rights (McGowan et al., 2016; Singh-Manoux, Adler, & Marmot, 2003). The capacity for self-determination (Ng et al., 2012) and freedom of choice is affected by our beliefs, our personal experience, and our public experience. These levels of experience are interdependent. Some people do not feel capable of advocating for their needs. Some health care providers deny patients respect and choice. For many people, autonomous decision making is constrained by social values, health policy or law. Each of these scenarios, separately or in combination, generates suffering and negative health consequences. This reality transcends political affiliation.
In daily practice, the collaborative relationship increases our ability to understand the civil rights and social determinant needs of our patients that if ignored, may negate health care efforts or worsen health status. As a field, CFHC can support research, health policy, legislation, and clinical designs that address the needs of all people, and particularly vulnerable populations. Including patients, families, and communities in health care delivery and design will improve quality of care and perhaps help bridge a political divide.

References


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