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FOCUS

The Big 6 Questions:

Changing the Paradigm of Pediatric Clinical Guidelines

This month's FOCUS looks at the MLPP's approach to multidisciplinary advocacy and the "Big 6" questions that we believe should be asked at every pediatric primary care visit.

This new paradigm for pediatric clinical intervention is the result of several years of MLPP research and observation in the primary and specialty care setting. By going beyond the usual clinical guidelines for primary care exams, pediatric and family medicine providers can better identify social and legal issues that are detrimental to their child patient's health and well-being. This model was initially presented by the MLPP at a UCONN Pediatric Residency Program training session in August 2005, and will be the subject of a future Pediatric Grand Rounds presentation at Saint Francis Hospital and Medical Center on December 9, 2005.

Is there enough food in the house?
Is there enough money for clothing and shelter?

What are the Big 6 Questions?

The MLPP has developed six simple questions for pediatric and family medicine providers to ask children and their families in the clinical setting to enhance pediatric care. While seemingly simple and intuitive, these are questions that pediatric providers tend not to ask in the course of well-care examinations absent certain indicators that would merit further consideration and amplification:

1. Do you have enough food in the house (is your child hungry on a consistent basis)?

2. Are your housing conditions safe (internally and externally) and stable?

3. Is there enough money in the house to pay for basic necessities (food, clothing, shelter, personal hygiene items)?

4. Have you encountered any problems with your health insurance company paying for services or medications (including dental and specialty care)?

5. Is your child receiving an appropriate education in the schools (has there been any problem with behavioral issues, has the child ever been suspended)?

6. Are you or your family victims of domestic violence?

Why should I ask these questions?

Traditional pediatric intake, which includes history and physical examination, does not delve significantly into social and legal issues. Literature suggests that there is a direct link between poverty and child health: the poorer the environment, the greater the likelihood that a child will suffer from chronic health problems. In addition, poor children are more likely to live in substandard housing that contributes to ill-health, such as environmentally exacerbated asthma and pulmonary illness. Educational opportunities are often limited by poorly funded school systems, and special needs children are frequently under identified, or misidentified, thereby denying these children appropriate educational services as mandated by federal and state law.

What is the theory behind addressing these issues in the medical setting?

The notion of "preventive pediatrics" addresses the issue of holistic medical intervention and the need for pediatricians to attend to more than traditional pediatric well-care. The pediatrician as quarterback for a team of professionals who can intervene on behalf of children at risk is an apt metaphor that captures the notion that advocacy and multidisciplinary intervention by health practitioners is not only an ideal; it is an expectation to be realized for every low-income family that seeks medical attention on behalf of their child.

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Won't these questions add significant time to my already burdened schedule?

It might add some additional time should the answers to these questions provoke the need for additional response or intervention. The theory, however, is to enable the medical provider to proactively intervene regarding poverty related issues that affect children's health. An additional few minutes during a well-care visit might prevent a child from consistently returning when a poverty related health care issue is identified, triaged, and addressed through interdisciplinary legal intervention.

What do I do when someone answers a question indicating that there is a problem?

At this point, the medical provider has three options. First, the provider may try to determine the exact nature of the complaint and its potential causes. For example, if a parent indicates that a kindergartner has been suspended three times during the school year for "behavioral issues," the provider might ask additional questions to determine the nature of the behavior at issue, the remedial steps taken by the school district, and whether there might be some connection between a clinical diagnosis and the demonstrated behavior, or whether the school district might be failing in its mission to provide adequate support services to its youngest students. The provider might then take the initiative to advocate on behalf of the child by contacting the appropriate school personnel (teacher, administrator, etc.).

Second, the provider could immediately call in a medical-legal advocate for an on-site consultation. With the family's express written permission, the provider would relay concerns directly to the MLPP (or other advocate) to explore advocacy solutions and determine whether the issue is one which is appropriate for intervention and potential representation. Third, the provider might refer the case to the medical-legal advocate's office (on site or through electronic means) and instruct the family to follow up directly with the advocate in the clinical setting or in the community, as appropriate.

What happens when a family indicates that domestic violence has occurred in the household? Do I have to report that to the Department of Children and Families (DCF)?

If examination reveals that the child has been subject to abuse or neglect, or has witnessed incidents of domestic violence, it is the legal obligation of the medical provider to report the incident to DCF. This is the double-edged sword that the provider faces: asking this question might result in a referral to DCF which would trigger a child welfare investigation, and perhaps DCF intervention. However, asking this question may ensure the physical safety and overall well-being of children in the household.

Does asking these questions make me a better pediatric provider?

Without question, many pediatric patients in Connecticut suffer from the ill effects of poverty, which in turn contribute to childhood illness and chronic medical conditions. Asking these questions provides a starting point for pediatric providers and legal advocates to address these determinants of child health and welfare.

Where can I find out more about preventive pediatrics?

For more information about these questions and how to apply them in pediatric practice, please contact the MLPP at 860-714-1412, or e-mail *jsicklic@kidscounsel.org.* For more on preventive pediatrics, please see Zuckerman & Parker; "Preventive Pediatrics - New Models of Providing Needed Health Services." 95 Pediatrics 758 (1995); Zuckerman, Sandel, Smith & Lawton, "Why Pediatricians Need Lawyers to Keep Children Healthy." 114 Pediatrics 224 (2004).

We Want to Hear from You!
Submit questions for the next edition of this newsletter to jsicklic@kidscounsel.org or, call Jay Sicklick at 860-714-1412. For information about the Medical-Legal Partnership Project, please check the MLPP website at www.ccmckids.org/mlpp, or go to www.kidscounsel.org/aboutus_programs_mlpp.

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SPOTLIGHT

Michael's Case: Home Nursing Care and Medicaid Advocacy

Michael is a 7 year old boy with spastic diplegia with left hip dislocation and right hip subluxation. Michael lived at home with his mother, Gina, and older brother. Gina called the MLPP because she had concerns with respect to Michael's home nursing care. She had requested 30 hours/week of a private duty nurse and 20 hours/week of a home health aide; the nursing agency was providing only 10 hours/week.

The MLPP did an immediate intake and investigation. Upon review, the MLPP attorney determined that since Michael was in receipt of Medicaid he rightfully qualified for 30 hours/week of a private duty nurse, as well as 20 hours/week of a home health aide, as his mother had initially requested. The MLPP attorney spoke with the managed care company responsible for Michael's health care, as well as with the contracted nursing agency. The nursing agency initially stated that they were unable to provide the full requested hours due to a nursing shortage. However, after several phone-conference negotiation sessions with both the nursing agency and the managed care company, a settlement was reached that met Gina's request for additional hours.

Gina is now receiving additional hours of care for Michael, giving her the ability to properly address her son's special health care needs.