Providing care for our Population with Special Health Care Needs
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An introduction to our obstacles in the special health care needs population:
Advocating for adequate health care in children with special health care needs is an essential part of our public health culture. Over 56 million Americans have special health care needs and as this patient population increases, we need to contemplate on how we treat our patients and confidently accommodate to their needs. A year ago, I recall treating a non-verbal adolescent patient at bedside who had onycholysis. His hallucal nail was barely attached and floating on the nail bed. His caregiver was unable to give us an adequate history or relate to us the pain that the patient was feeling. Previously, in the summer of 2016 some of the students at NYCPM received an extracurricular training for addressing patients/mentees with special health care needs (SHCN). We were taught that a caregiver is an individual who provides physical/emotional care for someone who has a disability or chronic illness. At this time, we learned the importance of the caregiver in our patient examinations. Usually, we rely on self-reported pain via general terms that we can extract from our patients. The VAS scale rarely fails to help patients express to us their level of pain. However, children with SHCN need a more unique and individualized system in communication. Often times the caregiver needs to be urged and guided so that we too can understand the patient’s pain and angst.

In podiatry, performing procedures at bedside and within an office setting is very exciting for students and residents and it is one of the things we love most about entering the field. However, when it comes to non-verbal patients, or those who lack communication skills, we often shy away from the challenge. We are not the only field who suffers from this interaction. In internal medicine, collecting the History of Present Illness is an important part of the exam that can pose as a challenge if a parent or caregiver is not aware of the problem and its infliction. In the dentistry field, students and dentists starting out in their career are troubled with the same insecurities. Like dentistry, we are a specialty that provides many services in an office setting that allows us to be in close contact with patients. We work hard on our social skills to earn the trust from patients who see us as strangers when they first sit in our examination chair. For a child with SHCN, it can be traumatizing allowing someone to get so close in an unfamiliar setting with different sights and sounds. These are things that we might find hard to be empathetic towards. However, an introduction to some of the differences in communicating with SHCN patients can make us feel much more confident with accepting this patient population into our offices. In 2009, data was collected by Weil et al on the behaviors and attitudes of dental students towards patients with disabilities. Many of them felt that they were never prepared for treating this population, which influenced their professional attitude and behavior. Even if there is a lack in education, understanding certain populations can provide a level of comfort and preparedness.

Initial interaction with SHCN patients:
Many disabilities are considered spectrum disorders because of their array of manifestations, so it is important to learn about the patient’s individually along with their comorbidities. When getting to know the patient, be aware of their hearing, vision and speech limitations as well as how they prefer to communicate. These can better improve the patient-provider relationship.
Throughout the exam, allow the patient to behave freely. Most likely their behaviors stem from a coping mechanism and can include twitching, fidgeting, rocking etc. which can help them become accustomed to a new environment. With patients that have regular visits, you may notice behavioral changes that may be altered by the slightest mood or change in energy level from the patient. Some of these changes can manifest in a change in body language such as a sudden loss in eye contact, which is normal. No matter the patient’s age, speaking to the patient as well as the caregiver can accelerate their level of comfort towards you as the practitioner. For patients who have difficulty with communication, it is still important to allow them to complete their sentences and to not assume what they are planning to say next, and patience is always key. Some techniques of nonverbal communication can be utilized, such as facial expressions to accompany speech (smile and nod for approval, shake head and frown for disapproval), gestures/demonstrations/sign language, and picture examples. Some techniques of verbal communication include talking slowly and clearly, explaining one step at a time in short sentences, relating the conversation to the patient’s interest, repeating yourself often, and checking for understanding. If your patient uses a communication device, make sure they have access to it and use multiple forms of instructions to help with clarity while being as specific as possible. With patients who have disabilities, “people-first language” can make all the difference, while avoiding negative terms such as “handicap”. There is hardly ever a need to mention a patient’s developmental disability, especially in podiatry.

Patients and pain:

In podiatry, we see that patients often neglect their lower extremity, but when it comes to pain, they will usually seek care. For patients with developmental disabilities, they normally have a long history of pain, including other medical problems and procedures that have caused pain, and different expressions or pain indicators that make the degree of pain difficult to assess. However, there are many ways to gather accurate information other than the VAS scale. When gathering this information, description or severity will often have to be tailored to the patient and their behaviors. In a 1998 article by McGrath, they used several categories for cues such as vocal, eating/sleeping, personality (less interaction), activity, facial expression, movement of body/limbs, and physiological cues (shivering) that expressed the patient’s pain level. While some of these
categories may either overlap, or be absent within the child’s spectrum of behavior, it was at least a baseline that could be used for long term patient care. In Crosta 2014 et al they reviewed many pain measurements for children with cognitive impairment. There were useful cues in the Pediatric Pain Profile, r-FLACC and the INRS, but a favorite was the NCCPC-PV 27 item pain scale. Within the requirements is a safeguard for accuracy that requires the physician to observe the patient for 10 minutes before drawing a conclusion.

Being able to provide these tools could take away the fear in treating patients with developmental disabilities or those requiring special health care needs. Apart from these tools, adopting good habits will help comfort this population of patients during in-office procedures which can be beneficial to them and your practice.

References


