Project ECHO: Sunflower Health Plan Case Presentation

Presentation Information
Series: Special Healthcare Needs

Session: Parent/Caregiver Support
Name: Jennifer Robinson
Date: 3/20/2025

Patient Information

Gender: ☒ Male ☐ Female
Age: 10 years
Race:

☐ American Indian/Alaskan Native Asian	☐ Native Hawaiian/Pacific Islander	☐ Multi-racial Other
☐ Black/African American	☒ White/Caucasian	☐ Prefer not to say

Ethnicity:

☐ Hispanic/ Latino	☒ Not Hispanic/Latino	☐ Prefer not to say

Strengths and Preferences (goals, motivators, preferences, Important to the individual)
Member has loving, supportive grandparents who are important to him and also one of his strengths. His family and caregivers engage with him to provide stimulation that his grandparents state he enjoys. It is important for member to stay as healthy as he can; his grandparents and caregivers provide daily care which is given consistently and per a routine that works best for him. Member can communicate some with his facial expressions which is also a strength for him. Member lives in a comfortable home and has his own room, where all of his supplies and equipment can be stored. He is able to have visitors and is also able to go outside in his wheelchair if the weather is nice.
Relevant Social and Trauma History (Current living situation, employment status, pertinent legal history, level of education, relationship status, children, support system, etc.)
Member was removed from bio parent's home in June 2018 and has lived with paternal grandparents (kinship foster care) since that time. Member does not have any contact from biological mother, father or sibling. His PGF has medical history of multiple myeloma for several years, with bone marrow transplant in September 2023. He continues a daily medication for this which causes fatigue. PGM had a hip replacement in February 2025 and will return to work outside the home when able. Member receives educational services under home bound status due to general decline in health.

Relevant Medical History (Diagnosis, conditions, etc.)	**Medication Summary** (Name, dose, frequency, route)
Member is a 10 year old male with history of CP, HIE secondary to cardiac arrest, refractory seizures on several AEDs, esophageal atresia s/p repair, dysphagia, GERD and slow motility, J tube dependent for feeding. Also has chronic respiratory failure, and is on continuous oxygen.	Clonazepam .5 mg 4x/day, Onfi 3 ml (2.5mg/ml) 2xday, Clonidine (0.02mg/ml) 2 ml at 6, 12, 6pm, MN. Zonisamide 125 mg 2x/day, Flovent 110 mcg 2 puffs 2x/day, Cuvposa (1mg/ml) 5 ml 2x/day and 1 additional dose daily as needed, Keppra (100mg/ml) 5.5 ml 3x/day, Albuterol 90mcg inhaler 2x/day, Melatonin 5 mg at bedtime, Omeprazole (10mg/ml) 2 ml 2x/day, Erythromycin (200mg/5ml) 1 ml every 6 hours, Topomax 3 ml 2x/day (25mg/ml), Diastat 7.5 mg as needed, Lorazepam .5 ml daily as needed (2mg/ml), Miralax ½ capful daily, Clobazam 4 ml 2x/day (2.5 mg/ml) Baclofen pump—filled by neurology.

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Lab Summary (Test, result, date, etc.)	**Toxicology Summary** (Test, result, date, etc.)
Click here to insert summary	Click here to insert summary
Substance Use History (Substance, age of first use, age where use became problematic, longest period of sobriety, how sobriety was achieved, method of use)	
NA	
Psychiatric History (Age of first mental health contact, past diagnosis, self-harming behavior, suicide attempts, etc.)	
NA	
Treatment Summary (Form of treatment, engagement in treatment, date entered, voluntary, etc.)	
NA	
Barriers to Treatment	
NA	