Project ECHO: Sunflower Health Plan Case Presentation

Presentation Information
Series: Transitions from Institutions
Session: Transitions from NFMH
Name: Susan Hocker
Date: 6/20/2024

Patient Information
Gender: ☐ Male ☒ Female
Age: 40
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 was identified by a NFMH navigator as a transition due to her desire to be out of a nursing facility. All communication occurs by writing things down due to her deafness.
Member is young, 40 years old.
Member is fairly stable in the nursing facility, will still occasionally have behavior issues. As member is moving closer towards transition, behaviors have been observed to escalate.
Member discussed goals which include getting a tattoo on her back. Talking to friends.
Member has Medicare and Medicaid.
Screened for the Brain Injury wavier and is approved for this waiver upon discharge from the NF.

Relevant Social and Trauma History (Current living situation, employment status, pertinent legal history, level of education, relationship status, children, support system, etc.)

Member is adopted. Participated in school through the 10th grade. Car accident causing a BI at the age of 17 yrs. old. Member has struggled with mental health since that time. No mental health records are in file pertaining to her childhood mental health needs except one note mention history of abuse between age 2 – 15yrs.
Member has had an incarceration for being a danger to others, determined to be caused by hallucinations. (no current legal issues)
Member is single, no children.
She has had only minimal employment. Occasionally working retail, but no longevity with employment.

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Relevant Medical History (Diagnosis, conditions, etc.)	**Medication Summary** (Name, dose, frequency, route)
Suicidal ideation, epilepsy, hypertension, major depression/severe psychotic symptoms, anxiety history of falling, difficulty walking (uses wheelchair) nicotine dependence schizoaffective disorder, bi-polar type Migraine Brain injury Asthma/emphysema/COPD Pain in various parts of body Wound care/pressure ulcers and history of wounds on feet and buttocks Other symptoms and signs involving cognitive functions and awareness. Hearing loss, not diagnosed, examinations have not identified any medical reason she cannot hear. She has had this issue for about 2 to 3 years.	Ativan 0.5mg PRN every 8 hours Bacitracin oint. 2/day wound on foot Clonazepam 0.5 2/day Docusate Sodium 100 mg 2/day Fluticasone Propionate 50 mcg/blist Gabapentin cap 300 mg 3/day Lactulose solution 20gm/30ml daily Levetiracetam tab 750 mg 2/day Levothyroxine Sodium tab 50 mcg daily Loratadine tab 10 mg daily Meloxicam Tab 7.5 mg 2 tab/daily Miralax 17mg daily Mitazapine tab 15 mg Olanzapine tab 5 mg 1 tab 2/day Pantoprazole Sodium tab 1 tab/ 2 day Propranolol 20 mg 1 tab 2/day Robitussin 100-10 PRN every 4 hours Topiramate tab 1 tab 3/day Triamcinolone acetonide 0.1% 2/day Venlafaxine HCl 1 cap 2/day Vit D# 25mcg 1 tab daily.
Lab Summary (Test, result, date, etc.)	**Toxicology Summary** (Test, result, date, etc.)
No lab reports on record at this time	No toxicology reports on record.
Substance Use History (Substance, age of first use, age where use became problematic, longest period of sobriety, how sobriety was achieved, method of use)	
Member smokes cigarettes	
Psychiatric History (Age of first mental health contact, past diagnosis, self-harming behavior, suicide attempts, etc.)	
Member has records dated from the early 2000's. Suicidal ideation has been consistent through her adult years Member has a history of outpatient therapies at mental health centers, at least 3 different centers. An inpatient stay at two mental health Hospital. An inpatient stay in a program for BI treatment/therapies.	
Treatment Summary (Form of treatment, engagement in treatment, date entered, voluntary, etc.)	

Currently Peer to Peer support in attempt to prepare member for living in the community.
Mental Health case manager to assist with supports member will need from mental health when she moves to the community.
NFMH team of a navigator, community mental health rep, peer to peer specialist and CTL, along with member have been meeting regularly to prepare member for next steps for discharge. Meet about every 3 to 4 weeks.

Barriers to Treatment

Member does not have family support or informal support. She has father who lives in a different state and is not involved with her. Member has an unexplained/untreated hearing loss.
Member will have exacerbation of behaviors as she moves closer to possible discharge.
Locating housing to best meet her needs, BI waiver she would need to be in an independent apartment.
As assisted living would provide supervision outside times caregivers are helping with ADL's and IADL's.