# Project ECHO: Sunflower Health Plan Case Presentation

**Presentation Information**
Series: **Health Equity in Community Health Settings**
Session: Health Equity
Name: Michelle L. Davis
Date: 10/31/2024

**Patient Information**
Gender: ☐ Male ☒ Female
Age: 60
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**)

- Strong Advocate for what she wants in life, and who she wants to surround herself with (kids, grandkids, community she enjoys closer to her daughter).
- Prefers living in an apartment not a nursing facility.
- Prefers living in the same city as her daughter and her grandchildren.
- Important to her is having a home has her own space and more than a shared room.
- Important to her is having money to pay rent, buy snacks, drink Coffee.
- Important to her is living where she can have her own space, and not share living with someone.
- Important to her is picking her own time to sleep, get out of bed, and not have employees coming and going in her personal space, unless she schedules them to work.
- Preference is to have staff close to her age (50's).

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

This individual lives with Chronic Renal Failure, Hypertension second other Renal, Heart Failure, Type 2 Diabetic, Schizophreniform disorder, anxiety disorder.

Currently living in an Assisted Living, as living in SNF until she was able to locate Dialysis Services in or near her hometown of choice. A few years ago, she admitted to a SNF after an extended Behavior Health in patient stay. The members CHF, Renal Failure, with a combination of mental health decline had taken tole on the member. She and her PCP regulated all medication, and she was admitted to the SNF to regulate her dialysis treatments. The individual when living on her own was not always attending her dialysis. Access to transportation, and care in the small town was limited, the dialysis center after multiple missed appointments stated that the patient was not following medical advice. Do to limited medical accesses in her community and closure of community hospitals, the individual was transferred to a larger city where she had more medical access to heart, and renal care.

She has a high school diploma and has a positive relationship with children and her grandchildren.

 *KDHE-Approved 3/20/2023*

# Project ECHO: Sunflower Health Plan Case Presentation

**The Story of access and limited access to SDOH: Access to dialysis care and mental health services to stabilize member health so that she had access to care of her choice.**

After living in a SNF for several years, the member requested transition services to help move the member to a small hometown she once lived. In addition, to live closer to her daughter and grandchildren to assist with a move back to her hometown and an extended SNF admission. The MCO transition team started working on placement with a hometown HCBS provider. The first step was to establish dialysis supports. The member attended three times weekly. The member was denied three dialysis placements in three different towns due to the referral paperwork and history with her hometown dialysis provider. There were different reasonings for the deny of care: The first choice of providers was the previous provider in the previous hometown where the member wished to return home stated her level of care was more than they could accommodate, and with her history of not following medical advice they would have to refuse services. Her first choice for hometown dialysis did not agree to place her on a seating waitlist unless the current provider was able to show stability and attendance for 6 months or longer. The other providers denied care because one provider was not in contract, and the other was an hour and a half drive one way to access care. The provider did not feel they could put the member through this travel stress 3 days weekly. The member set a goal to attend and follow the dialysis provider recommendation, attend all scheduled dialysis appointments, and obtain clinical documentation indicating she was making a positive, informed choice to accept her renal care and her mental health care. After a few months, the providers wrote the member a letter of recommendation and submitted it to the hometown dialysis center to transfer her dialysis care. The dialysis center accepted, and she was scheduled to be able to move and receive care in her chosen hometown.

# Project ECHO: Sunflower Health Plan Case Presentation

| **Relevant Medical History** (Diagnosis, conditions, etc.) | **Medication Summary** (Name, dose, frequency, route) |
|---|---|
| This individual lives with history of<br>-Renal failure,<br>-Congestive heart failure,<br>-Overactive gladder<br>-Nicotine Dependency<br>- Schizophrenia<br>-Muscle Weakness<br>-Need for assist with personal care | Ativan Oral tab 1 MG at Bed daily (Anxiety)<br><br>Carvedilol Tab 6.25 Mg 2-tab TID (Hypertension)<br><br>Fenofibrate oral tab 145 1 tab daily (hyperlipidemia)<br><br>Acetaminophen 325 mg 2 tabs daily for (discomfort / Pain)<br><br>Amlodipine Besylate tab 5mg daily (hypertension secondary to renal failure)<br><br>Magnesium Hydroxide Chews 2400 mg every 6 hrs. as needed for (constipation)<br><br>Melatonin 3 MG 2 tabs at bed (insomnia)<br><br>Seroquel XR Tab ext. release 50 MG (Schizophrenia)<br><br>Sevelamer HCl tab 800MG (end stage renal disease) |
| **Lab Summary** (Test, result, date, etc.) | **Toxicology Summary** (Test, result, date, etc.) |
| | None |

| **Substance Use History** (Substance, age of first use, age where use became problematic, longest period of sobriety, how sobriety was achieved, method of use) |
|---|
| The member chooses to smoke a vape nicotine pin. |



*KDHE-Approved 3/20/2023*

# Project ECHO: Sunflower Health Plan Case Presentation

| **Psychiatric History** **(Age of first mental health contact, past diagnosis, self-harming behavior, suicide attempts, etc.)** |
|---|
| -Schizophrenia<br>-Bipolar II Disorder.<br>-History of depression.<br>extended in patient behavior health admission |

| **Treatment Summary** **(Form of treatment, engagement in treatment, date entered, voluntary, etc.)** |
|---|
| The member does currently accept Outpatient Behavior Health treatment service monthly through the Nursing Facility BH provider; Case management Behavior Health support, Transportation |

| **Barriers to Treatment** |
|---|
| Member denies she has a behavior health disorder. Short term memory loss, Physical disability- reducing her ability to walk without walker support, denies she needs personal care assistance as much as she does to remain safe in her community setting. |