Project ECHO: Sunflower Health Plan Case Presentation

Presentation Information
Series: Transitions from Institutions
Session: Transitions from KDOC
Name: David Fout
Date: 6/13/2024

Patient Information
Gender: ☒ Male ☐ Female
Age: 34
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)

This individual is resilient and has shown slowly to potentially extend more trust towards their treatment team by agreeing to sign some ROIs and present less aggressively. This individual will be transparent in what they are thinking when they choose to speak about what is on their mind. Has started to engage in more responses, even if only offering one or two words at a time.

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

Individual is currently homeless and was homeless prior to being incarcerated with KDOC. While at the local jail, client was assaulted and incurred a brain injury prior to being returned to prison for a violation of their post release conditions. No natural supports have been identified by the individual or that we have found in our work towards placement. There was once a guardian on board, however the information was lost by the county office, and we have been unable to locate any guardianship records through the courts, or with the assistance of other agencies. Individual is currently on parole after serving time for Agg Battery, recklessly Bodily harm w/weapon (2023) There is an extensive criminal history from 2006 to current, primarily for misdemeanor offenses (Criminal Trespass, Theft, Illegal Camping with several battery charges between misdemeanor offenses). For the years that do not have offenses the individual was either committed at the state hospital or was serving time in a county jail.

Individual is generally unable to report histories that aren't based in delusion when interacting with parole and corrections staff. Often interactions with the client are cut short due to intimidating or threatening actions taken towards staff such as standing over an assessor, refusals to partake in an assessment or conversation. Records indicate that his psychiatric care dates to 1994 when his mother took him for help, but sessions would be cut short due to behaviors or threats to "tear up" items in the office. DCF first intervened with the client's case in 1994.

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Relevant Medical History (Diagnosis, conditions, etc.)	**Medication Summary** (Name, dose, frequency, route)
Hypothyroid Diabetes TBI Schizophrenia	Novolin U-100 Metoprolol Tartrate Metformin Levothyroxine 50mg Humulin R U-100 Divalproex 250 mg (Non-Compliant with medications at time of release)
Lab Summary (Test, result, date, etc.)	**Toxicology Summary** (Test, result, date, etc.)
Labs Refused Vitals – BP – 137/88 Pulse – 98 Temp 97 Weight – 120 (Height – 6'1") Pulse Ox 98	Negative for substances

Substance Use History (Substance, age of first use, age where use became problematic, longest period of sobriety, how sobriety was achieved, method of use)

Drug history not reported, during time with KDOC there was no drug use reported while incarcerated, no history of UA's being positive for substance use.

Psychiatric History (Age of first mental health contact, past diagnosis, self-harming behavior, suicide attempts, etc.)

Kansas PASSR Level II Notice of determination for Mental Illness 3/14, client does meet criteria for nursing facility level of care. Per state hospital records from 2023 client had non-compliance with medical treatment and regimen. Hospital records advise client was on 15 min observation check due to self-care failure. Per state Screen in 10/23 client advised admitted to hospital to avoid suicide and presented with psychosis and denial of diabetes. Long history of suicidal ideation and hospitalization. While incarcerated individual was in restrictive housing, or infirmary care due to self-care concerns. First diagnosis of hyperactive disorder was provided in 1994 at the age of 7.

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Treatment Summary (Form of treatment, engagement in treatment, date entered, voluntary, etc.)

History of hospitalizations with intermittent community engagement due to client refusals or non-compliance with treatment. Notes were located that indicated a history of IDD, however when planning eligibility for IDD was not found. Most assessments must be done based on file review and recent documentation of behaviors given communication is a significant barrier. Responses are generally requests to be left alone, shrugs, or refusals to offer information.

Barriers to Treatment

Client doesn't generally believe he is ill either physically or mentally which creates a barrier of non-compliance with medication and treatment. Given the severity of some physical health concerns such as the TBI, it creates a barrier of ineligibility for some services, that would be more applicable than others. Given the long history of aggressive behaviors, and criminal history, any form of residential placement is difficult to obtain, and so far, has been impossible. Individual is currently homeless and can only engage with case management and parole staff when staff seek him out in the community and look for him. Lately client has done a better job of engaging the community shelter and residing there in the evenings. Client will get up and leave when he is tired of engaging with a particular service or resource regardless of whether an assessment or meeting has finished.