Case Presentation Form

Presenting Provider Name: Natalie Gorman, LMSW
Presentation Date: April 9, 2020

Patient Biological Gender: Female **Patient Age: 78**

Race:

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

Ethnicity:

❒ Hispanic/Latino
X Not Hispanic/Latino
❒ Prefer not to say

Topics to discuss/areas of concern:

Team would like to explore additional supports with regards to nutrition and her history of cancer.

Pertinent Medical History:

Diagnosis:

Alcoholism
Aspiration Pneumonia
Carotid Artery Stenosis
COPD
Anemia, Unspecified
Dysphagia
History of Chemotherapy
Septicemia
Hypertension
Asthma
Moderate Malnutrition
Malignant Neoplasm of posterior wall of Oropharynx
Odynophagia
Peptic Ulcer Disease
Squamous Cell Carcinoma of Lung
Squamous Cell Carcinoma of Pharynx

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Psychiatric History:
Diagnosis:

No known psychiatric history. Member has reported periods of some depression at times due to several losses in her life. She also struggled significantly at the conception of her cancer diagnosis as well as when she had to undergo the surgery which left her with her trach. Member does report her relationship with God is important and He is who she depends upon during times of need. She also has support from her family. Currently, she is not on psychotropic medication. Previously, she was prescribed Xanax to help her remain calm and help ease her anxiety symptoms surrounding breathing issues as she adjusted to her trach

Details:
Family History: Member's grandson and son passed away of lung cancer; her sister passed away of cancer of larynx. Other family medical history includes alcoholism and diabetes. Other important family history would include poverty. Member reports raising a family being poor and even now financially struggles to have basic needs met. Member lives on disability alone in a small single level home. This home is in need of repair with noticeable damage to the roof and some structural issues. In addition, the home has a history of bed bugs due to uncleanliness. Even with the insurmountable challenges she has faced, this member continues to present with a clam spirit and pleasant demeanor.

Past Hospital Stays:
This member has had several in patient stays since this worker has been involved in her case. They are as follows: 2016- Hypertension; 2017- 6 inpatient stays for Pneumonia, chest pain, Acute Kidney Failure; 2018- 10 inpatient stays for Pneumonia, Acute Respiratory Failure, Dyspnea, and Encephalopathy; 2019-one in patient stay for Pneumonia; 2020- Shortness of breath. Last inpatient stay was in Jan 2020. Member is at greater risk for pneumonia due to her trach. Most recent stay shows member testing positive for Staphylococcus, Streptococcus and Pseudomonas. These bacteria are also noted on several other medical records during inpatient stays. The family reports member is discharged home normally with home health services, but sometimes not depending on the severity of the illness and has a nutritional consult upon discharge. This worker was not successful in locating any discharge paperwork identifying discharge instructions specific to member nutritional needs but did see where a nutritional consult was ordered. Member also has completed OT, ST and PT during many of her inpatient stays and has seen these therapies roll over for member to continue once she has returned home with the assigned home health agency.

Medication summary:
Member is to remain on 24/7 oxygen at 5 liters. Member is not compliant with using her oxygen at all times. Member receives several verbal prompts throughout the day to make sure she is wearing her oxygen. Additional medication list:

FERROUS SULF TAB 325MG OR
MILK OF MAGN SUS OR
AMLODIPINE TAB 5MG OR
LACTOBACILLU CAP OR
DONEPEZIL TAB 5MG OR
CYPROHEPTAD SYP 2MG/5ML OR
PANTOPRAZOLE TAB 40MG OR
ZYRTEC ALLGY CAP 10MG OR
PROAIR HFA AER IN
FENTANYL DIS 50MCG/HR TD
ONDANSETRON TAB 4MG OR
VALSARTAN TAB 160MG OR
ATENOLOL TAB 25MG OR
OXYCOD/APAP TAB 7.5-325 OR
ALBUTEROL TAB 2MG OR
METOCLOPRAM TAB 10MG OR

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Trauma History: (Age of significant traumas and brief summary)

Details:
There is nothing known about the member and any past trauma. From all reports the family states she is a true miracle. The family gives an example of her children and her sibling when they were each diagnosed with cancer, they did not appear to take the diagnosis seriously and continued to live an unhealthy lifestyle, i.e. continued to smoke, but this member did. Member did quit smoking and took the doctor recommendations seriously and did what she could to try and improve her health. She verbalizes the understanding some of her choices as a young adult were less than healthy (and the damage may already have been done) and not in her best interest, but she does what she can now to live a healthier lifestyle.

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

Details:
As mentioned, member lives alone in a small home. She has a full time caregiver providing for her needs on average 40 hours a week. She also has a male friend who comes over and keeps her company. She has extended family support who come and provide for her as informal supports. She does not have any legal issues known to this worker. As mentioned she has a male friend who comes and sees her several times a week and they enjoy each other's company. She is a loving woman who has a strong relationship with her God and believes she is still here on this earth for a reason. She reports she is not sure what that reason is as she smiles. Her sister is her DPOA and her daughter is her paid caregiver.

Trauma: There is not any information given which indicates any trauma has occurred nor has there been any reported to this worker.

Legal: No legal history is known for this member.

School: Member is reported to have completed the 10th grade.

Employment: Member is currently unemployed.

Pertinent Lab Work:

There are a fair amount of medical records for member in the file. The most recent lab numbers were from last inpatient stay from Jan 2020. Additional lab work may have occurred, however it was not available to this worker at the time of this presentation.

Sodium 131
BUN 205
Creatinine 0.80
WBC 14.60
RBC 4.14
Hemoglobin 11
Hematocrit 36%
Albumin 3.1

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Other:

Weight for the member has fluctuated in the last several months. Her height is 175 cm (5’8”). Her weight as per medical records has been as follows:

November 2019 46.27 kg (101 lb)
December 2019 47.63 kg (104.78 lb)
January 2020 64kg (140.8lb)
February 2020 46.44kg (102 lb)

Prior to becoming ill and needing to be on a feeding tube, member reports she was a healthy woman. She does have a history of alcoholism and smoking but as for nutrition, she reports she has always been slender for her height and has not been overweight. She reports she would cook meals for her family, and they would include proteins, vegetables and carbohydrates. She reports her children always had food to eat. She reports her nor were her family in need, even though they were quite poor. Member reports she was a good cook and loved to prepare meals for her family. She reports she was raised “home style cooking/meals” which did include fried food, but reports everyone worked hard and was more active “than kids today” so she felt it was a good balance. Since having her feeding tube, she is prescribed Jevity 1.5 calorie, 237 ml bottle as her sole nutrition and has 4 feedings a day. This information was obtained via medical records and her VPA reports in the home. This worker has also observed member giving herself a feeding during many visits in the home.

Substance Use History, if applicable: Besides the reported alcoholism there is no known report of any additional substance use.