Project ECHO: Sunflower Health Plan Case Presentation

Presentation Information
Series: Behavioral Health Supports
Session: 988 Overview
Name: Angie Kooken, LMSW
Date: 9/18/2025

Patient Information
Gender: ☐ Male ☒ Female
Age: 36
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 likes to make music and art. Also likes to design hardware. Member would like to live in an assisted living facility. Member is currently admitted to an inpatient unit until an appropriate residence can be identified.

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

Prior to being admitted to the inpatient unit, member was residing with her father and stepmother after being asked to leave the facility she was residing in so she would not end up in a homeless shelter. She was able to move into an RV on her father's property. Member cannot work at this time. On 5/14/2025, member posted a concerning message on social meeting. The BHCM at that time contacted multiple numbers noted in the member's chart but was unable to reach the member as well as emailed the member at two different emails found in the chart. Law enforcement was contacted to ask for a welfare check. When law enforcement responded to the request for a welfare check, no one was at the residence. BHCM was able to reach the member's father the following day and a message was to be relayed to member to contact BHCM. A mobile crisis unit was outreached to request a mobile crisis unit be dispatched to member's home. Upon arriving, the mobile crisis unit found no one at the residence. BHCM attempted to reach member three more times. Five days after the incident, BHCM was able to reach the member's father and spoke to the member. Member reported she was doing well. Member was not medication compliant. There was concern about thoughts to harm herself or others. Member suffers from psychosis and is often delusional, has loose associations. Member was hospitalized on 7/4/2025 7/5/2025 due to increased psychosis, paranoia and delusions. She did not believe she had schizophrenia, became erratic throwing things at family members. She reported her old case manager was following her. She remained until she was transferred to another IP unit on 7/15/2025. During this admission, the member has been stimulant seeking and sleeping a lot. The IP team thinks she is suffering from Factitious Disorder with some symptoms being somatic. Member agreed to go to an NFMH and the care assessment should start soon. Member remains admitted to the IP facility.

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Relevant Medical History (Diagnosis, conditions, etc.)	**Medication Summary** (Name, dose, frequency, route)
From claims and member's chart: Schizophrenia Unspecified Schizoaffective Disorder Bipolar Type Cannabis Dependence Nicotine Dependance Cigarettes Insomnia Epilepsy Conversion Disorder with seizures PTSD ADHD Unspecified Anxiety Disorder Unspecified Borderline Personality Disorder Cardiomegaly Depression Unspecified Autistic Disorder Esophageal reflux Asthma	From member's chart prior to IP admission (5/12/2025): Ondansetron 4mg PRN oral Docusate sodium 100mg PRN oral Quetiapine 300mg twice daily, 100mg in morning oral Trazodone 150mg at bedtime oral Divalproex DR 250mg daily, 500mg at bedtime oral Mirtazapine 30mg daily oral From discharge paperwork on 7/5/2025 Mirtazapine 15mg, take 3 tabs (45mg) at bedtime oral Cariprazine 4.5mg daily oral Zolpidem 5mg at bedtime oral Restart home medications
Lab Summary (Test, result, date, etc.)	**Toxicology Summary** (Test, result, date, etc.)
7/2/2025: WBC 6.1 Hgb 14.3 Hct 43.3 Plt 250 Na 137 K4.1 CO2 L 20 Cl 106 Cr 0.72 BUN 11 Glucose Random H 110 Ca 9.6 TSH with Reflex Free T4 2.02mclU/mL	7/1/2025: Undetected amphetamine, cocaine, cannabis, opiates, PCP, benzodiazepine, methadone, tricyclics, ethanol
Substance Use History (Substance, age of first use, age where use became problematic, longest period of sobriety, how sobriety was achieved, method of use)	
Admits to using marijuana daily, uncertain of any other information regarding this	
Psychiatric History (Age of first mental health contact, past diagnosis, self-harming behavior, suicide attempts, etc.)	
It appears this member has a long psychiatric history. She has been admitted to IP units 14 times since 2013. Member is a poor historian. Member has a long history of SI.	
Treatment Summary (Form of treatment, engagement in treatment, date entered, voluntary, etc.)	
Member continues to be admitted to an IP unit.	
Barriers to Treatment	
Member has not been discharged from her IP unit.	