Project ECHO: Sunflower Health Plan Case Presentation

Presentation Information

Series: Nursing Facilities and Quality of Life
Session: Community Transitions
Name: Michelle L. Davis
Date: 8/25/2022

Patient Information

Gender: ☒ Male ☐ Female
Age: 41
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

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

This Person currently would like to move back to his hometown community where he can be near his father who is intermittently involved in his life, and near where he has grown up. This person is currently living in an (MHNF) Mental Health Nursing Facility. This person would like to transition to the PD Home Community Base Waiver Program.

This Person has a work history. He was worked in a video store and fast food off and on in the last 7 years, and he verbalizes he liked working; would possibly want to work part time again once he has moved.
The individual has no legal history, he has a high school diploma, and is single.
He has interest in music, enjoys video gaming, would love to live where he can have a small animal for companionship. In addition, enjoys spending time with his dad, and moving to his hometown would allow him to see his dad weekly or more.

-Situations that he has experienced prior to his MHNF admit and inpatient state hospital admit: This man has experienced depression, anxiety, diagnosed with bipolar in his 20s and reports he finds social situations, where there are large crowds very hard to cope with, he will avoid interacting and keep to himself or leave the situation. He does not want staff that will linger; prefers they come three to four days a week, come in and get the work they must do done and leave. Admits he does need support in keeping his home clean and help organizing his medical affairs, he stated he has failed at this in the past and knows that keeping his home up alone is hard. As a child he lived with his father, he states was not always there for him. He would spend a lot of time alone. His mother passed away at a young age of 4 and he has no siblings.

He reports he must seek ongoing mental health treatment for his anxiety and bipolar disorder. The services he was enrolled in the small community were Behavior Health Case Management- they helped with Medication Passes, medical appointments, transportation to medical care and Psychotherapy. He has not utilized peer supports in the past when asked. He reports that his depression and anxiety did interfere with holding down a job and he has applied and receives Social Security Disability to supplement his income.

The individual has been in and out of an inpatient mental health hospital 3 times in the last ten years. He says that he was not coping well living on his own, did not always take medications, his physical health declined when he developed diabetes, and his depression and bi-polar sate became so difficult to manage he was admitted to a short-term mental health facility in early 2021.

What patient wants over the next 3 months: The individual wants staff to help with ADL/IADL to maintain his home, mental health, diabetic health, and nutritional support. He has had a history of hoarding and his home becoming non-livable without support staff helping him. He would also like a diabetic meter that he can use a phone to read his

glucose with. He reports he cannot take his own blood sugars; he is to shakey. Possibly a meter that is on his arm and applied once weekly by a nurse and use his cell phone for readings (not stick his fingers for readings).
-Help Finding social groups to meet others in his town
-Help to find staff supports if he moves out in his own apartment on the HCBS Waiver (Agency Directed Care) Does not want to live in an assisted living home.
-Wants help keeping the home clean; he has had a history of losing a live setting due to hoarding and cleanliness.
What has been working for the individual currently / Areas he wants help with
-Receiving verbal gentle reminders to keep all medical appointments and Behavior Health appointments by nursing home staff.
- in the past receive Behavior Health Case Management Daily to pass medication set up medical appt. and take to appt. Help with deciphering language and medical orders
-Currently has Nursing facility arranged talk therapy with a counselor with a local Psychologist every two weeks

Medical History (Diagnosis, conditions, etc.)	**Medication Summary** (Name, dose, frequency, route)
History of alcohol abuse Bipolar I recent mix sever psychiatric episodes Anxiety State, unspecified Dengeneration of hips	Medication: DULOXETINE CAP 30MG *QD Medication: METOPROLOL TAB 50MG ER *QD Medication: ATORVASTATIN TAB 10MG *QD Medication: BUSPIRONE TAB 5MG *TID Medication: CARAFATE TAB 1GM Discontinue Frequency: *Q 12 hrs. Medication: CETIRIZINE TAB 10MG *Q 24 hrs. Medication: CYMBALTA CAP 30MG *QD Medication: CYMBALTA CAP 30MG *QD Medication: JARDIANCE TAB 10MG *QD Medication: JARDIANCE TAB 25MG *QD Medication: KEFLEX CAP 500MG *QID Medication: LAMICTAL TAB 25MG *QD Medication: LAMICTAL TAB 100MG *QD Medication: LIQUITEARS SOL *BID Medication: METOPROLOL TAB 100MG ER *Q 24 hrs.

Medication: METOPROLOL TAB 50MG ER *QD
Medication: OLANZAPINE TAB 15MG *Q PM
Medication: OMEPRAZOLE CAP 20MG *QD
Medication: OZEMPIC INJ 2/1.5ML SC
Medication: TRAMADOL HCL TAB 50MG *PRN As needed
Medication: TRAMADOL HCL TAB 50MG *TID
Medication: ZYPREXA TAB 5MG *Q 24 hrs.
Medication: ZYPREXA ZYDI TAB 10MG *QD Daily

Lab Summary (Test, result, date, etc.)

Sodium	138		137 - 145 - mmol/L
Potassium	3.5		3.5 - 5.0 - mmol/L
Chloride	**92**	**L**	**98 - 107 - mmol/L**
Carbon Dioxide	**34.0**	**H**	**22 - 30 - mmol/L**
BUN	11		10 - 21 - mg/dL
Creatinine	0.68		0.66 - 1.25 - mg/dL
Bun Creatinine Ratio	16.2		8 - 36 -
Glucose	**253**	**H**	**70 - 99 - mg/dL**
Total Bilirubin	0.5		0.2 - 1.3 - mg/dL
ALT	**86**	**H**	**21 - 72 - U/L**
AST	54		17 - 59 - U/L
Alkaline Phosphatase	**150**	**H**	**38 - 126 - U/L**
Calcium	9.7		8.4 - 10.6 - mg/dL
Albumin	4.6		3.5 - 5.0 - g/dL
Total Protein	8.0		6.3 - 8.2 - g/dL
Estimated GFR African ımerican	>60		60 - 999 - ml/min/1.73
Estimated GFR Non African ımerican	>60		60 - 999 - ml/min/1.73

	Value		Reference Range
Hemoglobin A1c	**8.1**	**H**	**0.0 - 5.9 - %**

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)

Bi-polar onset at teen age years.
Sobriety year and a half.
Achieved sobriety through admission to State Hospital and later Level II mental health nursing facility.
Admits drinking beer, most any alcoholic substance

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

Project ECHO: Sunflower Health Plan Case Presentation

2012 Tylenol overdose and two other attempts prior to 2020
2017 Mental Health hospital short term stays treatment to evaluate medication 2 x prior to 2020
2019 Admit to State hospital for charges for assault
2020 admit to Long Term Care MHNF after released from State Hospital
7/2022 Suicidal Ideation ER visit
2022 Request to Transtion from MHNF to HCBS PD Services

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

Currently attends talk psychotherapy 1-2 x Monthly through Nursing Facility Telehealth
Psychiatric Services for medication Management
PCP/ APRN As needed at the MHNF
In his past-
Local Mental Health Case Management -Daily Medication Pass/ Doctor appointment support
Psychiatric Therapy and Psychology services
Wraparound services through mental health to manage home and health

Barriers to Treatment

In the past that was not working
-The Mental Health Case Manager has assisted in staffing, He will call the Mental Health Case Manager and cancel his appointments, not always follow his mediation regiment, and ask for help to release the staff from their duties. The Case Manager has explained to him to maintain and remain community-based care, taking medication, allowing staff to come in as scheduled, and being available to the staff allows for stability and a routine.
Other concerns the Nursing Staffing around transition from a NF to community
-He may not follow his diet, and his glucose will get out of control (currently orders pizza, tacos, donuts etc. His diabetic health is a concern)
-Not keep medical appointments as scheduled (procrastination on health care)
-Not take medication as prescribed
-Not keep a clean home to remain in an apartment complex
-Not walk his small animal and there be animal waste in the apartment
-Would not accept assisted living as a living setting
-Staffing providers are only Self-Directed options for the area that this person lives (no Agency Providers able to find staff supports, and he will have difficulty setting staff boundaries and applying rules under Self-Directed Care) example: staff possibly will take advantage of the situation possibly not keeping a routine that is favorable to the patients' health and care.
-Finds staff hard to get along with if they come in and clean or try to help him maintain his home (finds something wrong frequently with others who try to help). Especially if they ask questions or request his assistance.
-Finds it hard to cope with day-to-day (making a phone call to set appt, confronting a staff if they are not on time, anything that might interrupt something he is doing (gaming, sleeping)
-lacking problem-solving skills.