MOADD Case Presentation Form

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MOADD ECHO

Case Presentation Form

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Complete this form to the best of your ability. This case form is individualized and should only be completed and submitted by the listed provider. The link cannot be forwarded to another individual.

Before beginning to complete this form, please review the following:

- **ISP**
- **Treatment Plan**
- **IEP Plan**
- **Reunification Plan**
- **Verify as needed with the current caregiver for accuracy**

Feel free to reach out to other team members in order to obtain the needed information.

Please do not use any Protected Health Information (PHI)
When completing this form and presenting your case, please refrain from providing information containing names, initials, living location, place of work, birth date, or any specific information about the patient that helps identify them as this is considered "protected health information." It is our responsibility to ensure the privacy of protected health information is not disclosed.

Email our ECHO coordinator **Sarah Towne** at sarahtowne@health.missouri.edu if

you have any questions or comments.

PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any Expert Hub clinician and any patient whose case is being presented in a Project ECHO setting.

ECHO ID: MOADD073

Presenting Provider: April Gordon

Role of presenter:
* must provide value

Assistant Director

Co-Presenter Name(s) and roles:

Presentation Date: 2024-04-03 Y-M-D

Please answer the following questions about your clinic or agency:

What type of Clinic/Facility/Care Provider are you? Behavioral health community provider

Clinic/Facility Name: Ozark Center-Will's Place

Clinic/Facility City: Joplin

Clinic/Facility Zip Code: 64804

Clinic/Facility Phone Number: 417-347-7580

Clinic/Facility Fax Number: 417-347-9238

Demographic Information

Gender:

(•) Male ( ) Female ( ) Non-binary ( ) Other

Person Age: 14 (Yrs)

(Mos)

Funding Type for person's services: Medicaid

Insurance Company: MOHealthnet

Race: White/Caucasian

Ethnicity: Not Hispanic/Latino

What concerns would you like help with for this person?

Please list up to three concerns:

1)

Physical aggression-attacks mom and dad, threw items at IIS worker, verbally threatening toward therapist and homebound instructor; destroys property

2)

3)

Case Intervention Details

Please list some strengths of this person:

Please indicate if you use any of the following strategies with this person:

- [ ] 1. Use of visual aids
- [x] 2. Incorporation of person's special interest onto the session
- [x] 3. Increased involvement of family members
- [ ] 4. Accommodations for person's sensory sensitivities
- [ ] 5. Explicit didactics about emotions
- [ ] 6. Posted agenda of therapy session

The following plans are in place:

- [ ] Communication Plan
- [x] Treatment Action Plan
- [x] Crisis Plan

Communication Ability and Sensory Concerns

What is the developmental disability? (intellectual, autism, physical, cerebral palsy, etc)

Autism

What are the substantial functional limitations?

- [ ] Receptive and Expressive Language
- [ ] Self-Care
- [x] Learning
- [ ] Mobility
- [x] Self-direction
- [ ] Capacity for Independent Living
- [ ] Economic Self-Sufficiency
- [x] Social/leisure skills
- [x] Health and Safety skills

Communication Ability **(Please indicate the patient's highest communication)**

- [ ] Nonverbal (i.e., no functional words)
- [ ] Uses gestures (e.g., pointing, waving and/or leads other to wants/needs)
- [ ] Uses single words
- [ ] Uses 2-3 word phrases
- [ ] Uses sentences
- [x] Chats with others (e.g., reciprocal conversation)
- [ ] Uses sign language
- [ ] Uses special communication device

Sensory Concerns

- [ ] Sensitive to noise
- [ ] Textures
- [ ] Smells non-food items
- [ ] Sensitivity to touch
- [ ] Sensitivity to crowds of people
- [ ] Sensitivity to lights
- [ ] High pain tolerance
- [ ] Low pain tolerance

Severity Level of Sensory Concerns:

(•) Minimal ( ) Moderate ( ) Severe

Additional Comments:

Behavior History

	Never	Rarely (1/week)	Sometimes (2 - 4/week)	Usually (5 +/week)
Anxious or worries	○	○	○	○

Short attention span	○	○	○	○
Hyperactivity	○	○	○	○
Obsessive-Compulsive	○	○	○	○
Aggressive toward others	○	○	◉	○
Hurts animals or other people	○	○	◉	○
Unusual or excessive fears	○	○	○	○
Depression	○	○	○	○
Defiant	○	○	◉	○
Self-Injury (head banging, head punching, biting, scratching, cutting, picking, etc)	○	◉	○	○
Toileting issues or accidents	○	○	○	○
Irritability/Moodiness	○	○	◉	○
Hallucinations	○	○	○	○
Food seeking	○	○	◉	○
Pica (eating non-food items)	○	○	○	○
Public masturbation	○	○	○	○
Sexualized behavior concerns	○	○	○	○
Property destruction	○	○	◉	○
Fascination with water	○	○	○	○
Elopement	○	○	○	○
Impusivity	○	○	◉	○
Homicidal concerns	○	○	◉	○
Suicidal concerns	○	◉	○	○

Involuntary movements	○	○	○	○
Substance Use/Misuse (tobacco, alcohol, cannabis, etc.)	○	○	○	○

Severity Level of Behavior Concerns

○ Minimal ○ Moderate ◉ Severe

You indicated that the person is aggressive. Who are they aggressive with? (Check all that apply)

- ☑ Mom
- ☑ Dad
- ☑ Other caregiver
- ☐ Sibling/s
- ☐ Peers
- ☑ School Staff
- ☐ Home Staff
- ☐ Strangers
- ☑ Outpatient Providers
- ☐ Other

You indicated that the person has self-injurious behaviors. Briefly detail the behavior(s):

History of self-harm/threats of self-harm when in trouble

Please describe how the person is aggressive:

Attacked mom, possibly broke dad's nose, broke door off, put holes in walls, drew finger across neck at IIS worker, threw items at IIS worker, verbally aggressive toward therapist

You indicated that the person has self-injurious behaviors. Has there been a need for any medical intervention?

○ Yes ◉ No ○ N/A

You indicated the person has homicidal or suicidal concerns. Please indicate the level the patient has thought through such plans.

- ☑ Homicidal/Suicidal Thoughts
- ☐ Homicidal/Suicidal Plans
- ☐ Homicidal/Suicidal Attempts

Has there been a functional behavior assessment done for behaviors the behaviors of concern?

○ Yes ○ No

Has there been a significant loss of skills? (e.g., daily living, self-help, academic)

○ Yes ◉ No

Additional Comments:

Mental Health Treatment History

Please list current psychosocial treatments: (Note: medications are not included in this section)

Please list the current behavioral health diagnoses:

Autism, DMDD, IED, and ADHD

Treatment type (e.g., cognitive-behavioral therapy, play-based therapy, family therapy):

Therapy, case management, medication management

Frequency type (e.g, weekly, monthly)

Weekly

Age when started:

(Yrs)

Reason for treatment:

behaviors

Is it helping?

No

Comments:

Treatment type (e.g., cognitive-behavioral therapy, play-based therapy, family therapy):

Treatment type (e.g., cognitive-behavioral therapy, play-based therapy, family therapy):

Are there any psychosocial treatments that have been previously tried, but discontinued? If so, please list treatments here and explain why they were discontinued.

Therapist has likely discontinued seeing client due to aggression.

Medical/Psychiatric History

Please list all diagnoses or illnesses:

Diagnosis/Illness: Autism, DMDD, IED, and ADHD

Age of diagnosis:
(Yrs)

Date - Year:

Professional making diagnosis:

Is this person still a patient of this professional?

○ Yes ◉ No

Diagnosis/Illness:

Please list current medications and supplements:

Medication:

Additional medications:

Previous Psychotropic Med Trials:

CHECK ALL CLASSES THAT APPLY:
Please have available the name of the drug and the highest dose of any medication for which a box is checked.

- ☐ Stimulant: Dexedrine, Dextrostat, ProCentra, Vyvanse, Concerta, Daytrana, Methylin, Ritalin, Adderall, etc.
- ☐ Alpha agonist: Guanfacine (Tenex), Guanfacine ER (Intuniv), Clonidine, etc.
- ☐ SSRI/SNRI: Citalopram (Celexa), Escitalopram (Lexapro), Fluoxetine (Prozac), Paroxetine (Paxil, Pexeva), Sertraline (Zoloft), etc.
- ☐ Monoamine Oxidase Inhibitor: Isocarboxazid (Marplan), Phenelzine (Nardil), Selegiline (Emsam), Tranylcypromine (Parnate), etc.
- ☐ Other antidepressant
- ☐ Non-SSRI anxiolytic: Benzodiazepene or Buspirone
- ☐ Anticonvulsant mood stabilizer: Carbamazepine, Divalproex and Lamotrigine, Gabapentin, Topiramate, etc.
- ☐ Typical antipsychotic: Haldol (haloperidol), Loxitane (loxapine), Mellaril (thioridazine), Moban (molindone), Navane (thiothixene), Prolixin (fluphenazine), Serentil (mesoridazine), Stelazine (trifluoperazine), etc.
- ☐ Atypical antipsychotic (other than Clozapine)
- ☐ Clozapine
- ☐ Lithium
- ☐ Hypnotic: Zaleplon (Sonata), Eszopiclone (Lunesta), Triazolam (Halcion), Estazolam, Temazepam (Restoril), Ramelteon (Rozerem), Suvorexant (Belsomra), etc.
- ☐ Sleep Medication: Clonidine, Trazodone, Remeron, Doxepin, etc.
- ☐ Other

Please check all of the following that apply:

- ☐ Seizures
- ☐ Heart Problems
- ☐ Constipation
- ☐ Nausea/Vomiting
- ☐ Vision Changes

- [ ] Insomnia/Sleep concerns
- [ ] Trouble Swallowing
- [ ] Stomach ache/pain/reflux
- [ ] Staring Spells
- [ ] Dental carries/pain
- [ ] Diarrhea
- [ ] Chronic Ear Infections
- [ ] Headaches
- [ ] Menstrual
- [ ] Environmental Allergies
- [ ] Skin Problems (e.g., rash, eczema)
- [ ] Urinary Tract Infection (UTI)

Testing

Have the following tests been performed?

Chromosomal Microarray

○ Yes ○ No ○ Unknown

Fragile X DNA

○ Yes ○ No ○ Unknown

MRI of the brain

○ Yes ○ No ○ Unknown

EEG

○ Yes ○ No ○ Unknown

Sleep study

○ Yes ○ No ○ Unknown

Academic testing

◉ Yes ○ No ○ Unknown

Results:

IEP in place

Intelligence testing

◉ Yes ○ No ○ Unknown

Results:

IQ of 94

Any additional comments:

Sleep History

Rarely = never or 1 time/week; **Sometimes** = 2-4 times/week; **Usually** = 5 or more times/week

Does this person fall asleep within 20 minutes? If yes, how often?

○ No ○ Rarely ○ Sometimes ○ Usually

Does this person co-sleep? If yes, how often?

◉ No ○ Rarely ○ Sometimes ○ Usually

Does this person awaken more than once during the night? If yes, how often?

○ No ○ Rarely ○ Sometimes ○ Usually

Does this person snore loudly?

○ No ○ Rarely ○ Sometimes ○ Usually

Does this person seem tired during the day? If so, how often?

○ No ○ Rarely ○ Sometimes ○ Usually

Comments:

He is currently staying up all night.

Trauma/Abuse History

	Yes	Suspected	No
Trauma/Abuse History	○	○	◉
Physical Abuse	○	○	◉
Sexual Abuse	○	○	◉
Intrauterine Exposure to Alcohol/Drugs	○	○	◉

Comments:

Social History

This person resides with: Mother

Is this person the legal guardian? (•) Yes ( ) No

Does the legal guardian have limited or full custody? Full Custody

How many people live in the home *not* including this person? 1

List any other significant relationships important to this person (e.g., family, friends, grandparents, neighbor)

Dad and grandparents

Additional Comments:

Family History

Condition/Disorder

	Mom	Dad	Brother	Sister	Mat GM	Mat GF	Pat GM	Pat GF
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder (e.g., epilepsy)	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Concerns (e.g., Depression, Anxiety Disorder, Bipolar)	☐	☐	☐	☐	☐	☐	☐	☐
Substance misuse/addiction	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Educational History

Grade in School: 8th

Ever repeat a grade? ○ Yes ○ No

What best describes the child's current education program or setting?

- ☐ Full time in education regular class
- ☐ Time split between regular and special education classes
- ☐ Full time special education
- ☐ Aide/Paraprofessional or extra help
- ☐ Home School
- ☐ Virtual Learning
- ☐ Alternative School
- ☑ Homebound

Can this person read? Yes

Are there learning problems? (Please check all that apply)

☐ Math ☐ Reading ☐ Writing

Legal History

Does this child have a prior or current legal case? Yes

What type of case? Criminal

Please provide any pertinent details about the legal case.

Head butted a JO and is being charged with assaulting an officer. Upcoming court date.

Resources

Resources (Check all that apply):

- ☐ Bureau of Special Health Care Needs
- ☐ Behavioral Therapy/ABA
- ☑ Easter Seals
- ☐ Speech Language Therapy (SLT),
- ☐ Physical Therapy (PT)
- ☐ Occupational Therapy (OT)
- ☑ Regional Office/SB40 Board (Dept. of Mental Health)
- ☑ Juvenile Office
- ☑ Children's Division

- [x] Community Mental Health Services
- [x] Community Psychiatric Rehab
- [x] Community Psychiatrist
- [x] Social Security Disability (SSI)
- [ ] Waiver Services
- [ ] None of the above
- [ ] Other

How often do representatives/workers from these resources communicate?

- [ ] Annually
- [ ] Quarterly
- [ ] Monthly
- [x] Weekly
- [ ] Do no communicate
- [ ] Other

How do resource representatives share care plans, progress notes, problems or concerns?

- [x] Meetings
- [x] Phone Calls
- [ ] Email
- [ ] Do not share information
- [ ] Other

What are the barriers to the resource representatives and family/caretakers meeting regularly and sharing strategies?

- [ ] Time/Scheduling
- [ ] Transportation
- [ ] Funding/Financial barriers
- [ ] Lack of rapport/therapeutic relationship
- [x] Other

Please Identify Other Barriers:

Short staffed

Additional Comments:

Form Status

Complete? Complete