Behavior Solutions In Hospitals Case Presentation

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ECHO Autism: Behavior Solutions in Hospitals

Case Discussion Form

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Complete this form to the best of your ability. This survey is individualized and should only be completed and submitted by the listed presenter. A unique confidential ID number (ECHO ID) has been provided that must be utilized instead of identifying information.

Email our ECHO Autism coordinator **Michael Hansen** at *michaelhansen@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 clinician and any person whose case is being presented in a Project ECHO setting. All case discussions are for professional development in a learning collaborative setting and the responsibility for any changes to services, care, plans rest with the individual who is supporting/serving the person being discussed.

ECHO ID:

BSIH19

Presenter Name:

* must provide value

Stacey Brandjord

Phone Number:

* must provide value

(507) 828-0339

Co-Presenter Name(s):

Presentation Date:

2024-04-29

Please Answer the following questions about your Hospital or Health System:

Where do you provide service?

* must provide value

- [ ] Psychiatric Inpatient Unit
- [x] Emergency Department
- [ ] Medical Inpatient Unit
- [ ] Other

Check all that apply

What type of healthcare system do you work in?

* must provide value

- [ ] Community Critical Access Hospital
- [ ] Tertiary medical center (receives transfers from other hospitals)
- [x] Free standing Children's Hospital
- [ ] Free standing Psychiatric Hospital
- [ ] Hospital within a Hospital (peds within adult hospital, psychiatric hospital within a main hospital)
- [ ] Other

City:

* must provide value

Minneapolis

State:

* must provide value

Minnesota

Zip/Postal Code

* must provide value

55417

What services are available at your facility?

- [ ] Child Life
- [x] Behavior Crisis Team
- [x] Psychiatry Consults
- [x] Psychologist(s)
- [x] Social Worker(s)

- [ ] Other
- [ ] None

Check all that apply

Does your facility train staff in protective measures for working with patients with behavioral risk?

* must provide value

- ( ) Yes
- ( ) No
- (•) I don't know

Which of the following patient safety resources are available at your facility:

* must provide value

- [x] Arm immobilizers
- [ ] Helmets
- [ ] Kevlar vests
- [ ] Bite guards
- [ ] Fluid shields
- [ ] Personal protective padding
- [ ] Padded room
- [ ] Sensory friendly room
- [ ] Hair ties
- [x] Physical restraints (e.g., soft and 4-point restraints)
- [x] Room staff
- [ ] Posey beds
- [ ] Other
- [ ] I don't know
- [ ] None

Check all that apply

Which of the following staff safety resources are available at your facility?

* must provide value

- [ ] Arm immobilizers
- [ ] Helmets
- [ ] Kevlar vests
- [ ] Bite guards
- [ ] Fluid shields
- [ ] Personal protective padding
- [ ] Hair ties
- [ ] Room staff
- [ ] Other
- [x] I don't know
- [ ] None

Do you have a team that specifically supports safe care delivery related to patients with developmental or behavioral needs?

* must provide value

- ( ) Yes
- (•) No
- ( ) I don't know

Please answer the following questions about your case:

What was your patient's sex assigned at birth?

* must provide value

- ( ) Male
- (•) Female
- ( ) Other

What gender does your patient identify with?

* must provide value

- (•) Girl/Woman
- ( ) Boy/Man
- ( ) Identity not listed
- ( ) Prefer not to say
- ( ) Other

Patient Age:

* must provide value

14

Insurance:

* must provide value

- [ ] None
- [x] Medicaid
- [ ] Medicare
- [ ] Private
- [ ] Other

Check all that apply

What is the patient's race?

* must provide value

- [ ] American Indian or Alaskan Native
- [x] Asian Black or African American
- [ ] Caucasian/White
- [ ] Canadian Indigenous or Aboriginal
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Other
- [ ] Do not wish to provide
- [ ] I don't know

Check all that apply

What is the patient's ethnicity?

* must provide value

- ( ) Hispanic or Latino origin
- (•) Non-Hispanic or Non-Latino origin
- ( ) Other
- ( ) Do not wish to provide
- ( ) I don't know

What is the main language spoken in the home?

English

Which other languages are spoken in the home?

- [ ] English
- [ ] Arabic
- [ ] Burmese
- [ ] Chinese (e.g., Mandarin, Cantonese)

- [ ] French
- [ ] Navajo
- [ ] Spanish
- [ ] Tagalog
- [ ] Vietnamese
- [ ] Other

Does the patient have an autism diagnosis?

- (•) Yes
- ( ) No

Presenting Issue

Is this person currently receiving active acute care in your facility?

* must provide value

- (•) Yes
- ( ) No

What is their current number of days in the hospital?

* must provide value

37

Acute medical presenting issue(s)

* must provide value

- [ ] Pain
- [ ] Fever
- [ ] Dehydration
- [ ] Seizures
- [ ] Known physical injury (e.g., accident, assault)
- [ ] Unclear but acting unusually
- [x] Other

Check all that apply

Acute psychiatric/behavioral presenting issue(s)

* must provide value

- [x] Self-harm
- [ ] Suicidal thoughts
- [x] Aggression
- [ ] Hallucinations
- [ ] Unclear but acting unusually
- [ ] Other

Check all that apply

Pain Assessment

What is the patient's tolerance for pain:

- ( ) Low
- ( ) Typical
- ( ) High
- (•) Unknown

How do you know the patient is in pain (signs/communication):

- [ ] Cries
- [ ] Facial expressions
- [x] Verbalizes pain
- [x] Hurting self/self-injury
- [x] Aggression to others
- [x] Changes in behavior
- [ ] Decreased frustration tolerance
- [ ] Gets quiet/shuts down
- [ ] Shaking/rocking
- [ ] Changes in breathing
- [ ] Communicates pain using identified form of communication
- [x] Point/gesture
- [ ] Unknown
- [ ] Other

Check all that apply

Comments about pain assessment

Communication Assessment

How does your patient communicate?

- [x] With single words or short phrases
- [ ] With complex sentences
- [ ] With a speech generating device
- [ ] With pictures or visuals
- [ ] With sign language or hand gestures
- [ ] Typing/texting
- [ ] Other

Check all that apply

What is the patient's dominant language when communicating with others?

English

Does the patient require a support person to help them communicate?

- ( ) Yes
- (•) No
- ( ) I don't know

Comments about communication

Support Needs Assessment

Sensory Sensitivities

- [x] Sensitive to noise
- [x] Textures
- [ ] Smells non-food items
- [x] Touch
- [ ] Crowds of people
- [ ] Lights
- [x] Other
- [ ] None
- [ ] I don't know

Check all that apply

Other:

Level of Sensory Sensitivities:

- ( ) Minimal
- (•) Moderate
- ( ) Severe
- ( ) I don't know

When the patient is stressed, what helps them feel more comfortable?

- [ ] Object, please indicate:
- [ ] Person, please indicate:
- [x] Environment change
- [ ] Other

Check all that apply

What environment change(s) help the patient feel more comfortable?

- [ ] Low light
- [ ] Low sound
- [x] Minimal talking
- [ ] Limited physical touch
- [ ] Tactile pressure
- [ ] Visual supports
- [ ] Other

Check all that apply

How does the patient take medications?

- [x] Swallows pills
- [x] Chews pills
- [ ] Drinks liquid

Does the patient typically take medication reliably?

- ○ Takes all doses as prescribed
- ○ Misses less than 50% of doses
- ○ Misses more than 75% of doses

Safety Assessment

Interfering Behaviors

* must provide value

- [ ] Anxious or worries
- [x] Short attention span
- [x] Hyperactivity
- [ ] Obsessive-compulsive
- [x] Aggressive towards others
- [ ] Unusual or excessive fears
- [ ] Depression
- [x] Defiant
- [x] Self-injury (e.g., head banging, head punching, biting, scratching, cutting, picking, etc.)
- [x] Irritability/Moodiness
- [ ] Hallucinations
- [x] Food seeking
- [ ] Pica (i.e., eating non-food items)
- [ ] Public Masturbation
- [ ] Sexualized behaviors
- [ ] Property destruction
- [ ] Fascination with water
- [x] Elopement/Wandering
- [x] Impulsivity
- [ ] Homicidal concerns
- [ ] Suicidal concerns
- [ ] Involuntary movements
- [ ] Other
- [ ] None

Check all that apply

What triggers interfering behavior(s)?

* must provide value

- [x] Unexpected changes
- [x] Transitions
- [ ] Fear
- [ ] Pain
- [x] Non-preferred tasks
- [x] Lack of communication
- [x] Interrupting impulsive behaviors
- [ ] Interrupting obsessive/compulsive behaviors

- [ ] Illness
- [ ] Anger
- [ ] Unfamiliar people
- [x] Unfamiliar or changed environments
- [ ] Missed medications
- [ ] Change in sleep cycle
- [ ] Constipation
- [ ] Other
- [ ] I don't know

You indicated that the patient is aggressive. Who are they aggressive with?

* must provide value

- [ ] Mom
- [ ] Dad
- [x] Other caregiver
- [ ] Sibling/s
- [ ] Peers
- [x] School Staff
- [x] Home Staff
- [ ] Strangers
- [ ] Outpatient Clinician
- [x] Hospital Staff
- [ ] Spouse
- [ ] Own child/children
- [ ] Housemate/roommate
- [ ] Other
- [ ] I don't know

Check all that apply

You indicated that the patient has self-injurious behaviors. If the patient engages in head banging or head punching, did you assess for a concussion?

* must provide value

- ( ) Yes
- ( ) No
- (•) Not applicable

Severity Level of Behavior Concerns

* must provide value

- ( ) Minimal
- (•) Moderate
- ( ) Severe
- ( ) I don't know

What does the patient need to stay safe?

* must provide value

consistent routine, consistent communication,

What does the staff need to know to stay safe?

* must provide value

how to best communicate with her - reduced language, redirection of behaviors instead of PRN meds/restraint

Comments:

Assessing the Patient's History

Please check all of the following that apply:

- [ ] Seizures
- [ ] Heart Problems
- [x] Constipation
- [ ] Nausea/Vomiting
- [ ] Vision Changes
- [ ] Fever
- [ ] Trouble Swallowing
- [ ] Stomachache/pain/reflux
- [ ] Staring Spells
- [ ] Dental caries/pain
- [ ] Diarrhea
- [ ] Chronic Ear Infections
- [ ] Headaches
- [x] Menstrual Discomfort/Mood Change
- [ ] Environmental Allergies
- [ ] Skin Problems (e.g., rash, eczema)
- [ ] Other

Mental health

Mental Health treatments the patient is currently using (does not include medications):

- [ ] Applied Behavioral Analysis Therapy
- [ ] Group Therapy
- [ ] Individual Therapy
- [ ] Family Therapy
- [ ] Cognitive-Behavioral Therapy
- [ ] Play-Based Therapy
- [ ] Partial Hospitalization/Day Treatment
- [ ] Other
- [ ] None
- [ ] I don't know

Check all that apply

Medications

Does this patient take any medications?

* must provide value

- (•) Yes
- ( ) No

Currently, is the patient taking medications for any of the following?

* must provide value

- [x] Behavior
- [x] Sleep
- [x] Constipation
- [ ] Allergies/Asthma
- [x] Seizures
- [ ] Other

Please select which medication(s) the patient is taking for behavior:

- [ ] Adderall
- [ ] Adderall XR
- [ ] Aripiprazole (Abilify)
- [ ] Clonidine (Kapvay)
- [ ] Concerta
- [ ] Daytrana
- [ ] Dexmethylphenidate
- [ ] Dextroamphetamine
- [ ] Dextroamphetamine-salts
- [ ] Fluoxetine (Prozac)
- [ ] Focalin
- [ ] Focalin XR
- [ ] Guanfacine (Intuniv/Tenex)
- [ ] Lisdexamfetamine (Vyvanse)
- [ ] Metadate
- [ ] Metadate CD
- [ ] Methylphenidate
- [ ] Mixed dextroamphetamine salts
- [ ] Propranolol
- [ ] Quillivant
- [ ] Risperidone (Risperdal)
- [ ] Ritalin
- [x] Seroquel
- [ ] Sertraline (Zoloft)
- [ ] Strattera (Atomoxetine)
- [ ] Other

Please select which medication(s) the patient is taking for sleep:

- [x] Melatonin
- [ ] Clonidine
- [ ] Other

Please select which medication(s) the patient is taking for constipation:

- [ ] Polyethylene Glycol (MiraLAX)
- [ ] Fiber
- [x] Docusate (Colace)

Please select which medication(s) the patient is taking for seizures:

- [ ] Carbmazepine (Carbatrol)
- [x] Depakote
- [ ] Divalproex
- [ ] Other
- [ ] Keppra
- [ ] Lamotrigine (Lamictal)
- [ ] Lithium
- [ ] Topiramate (Topamax)
- [ ] Valproate/Valproic Acid
- [ ] Zonisamide

Was this patient prescribed medication(s) in the acute care setting?

* must provide value

- (•) Yes
- ( ) No

Please select which medication(s) the patient was given for agitation in the acute care setting:

- [ ] Versed (Midazolam)
- [x] Haldol (Haloperidol)
- [ ] Thorazine (Chlorpromazine)
- [ ] Ketamine
- [x] Zyprexa (Olanzapine)
- [x] Hydroxyzine
- [ ] Diphenhydramine
- [ ] Risperdal
- [ ] Clonidine
- [ ] Lorazepam
- [ ] Other

Please select which medication(s) the patient was given for pain in the acute care setting:

- [ ] Morphine
- [ ] Toradol
- [x] Ibuprofen
- [ ] Percocet
- [ ] Acetaminophen
- [ ] Other
- [ ] Local measures (e.g., heating pad, ice, topical medication)

Outpatient Care Team

What other professionals serve your patient when not in an acute care setting?

* must provide value

- [x] School staff
- [x] Support coordinator
- [x] Psychiatrist
- [ ] Therapist (mental/behavioral health)
- [ ] Therapist (SLP/OT/ABA)
- [x] Family
- [ ] Primary Care Clinician
- [ ] Other
- [ ] I don't know

Who is the in-patient team communicating with while the patient is in the acute care setting?

* must provide value

- [x] School staff
- [ ] Support coordinator
- [ ] Psychiatrist
- [ ] Therapist (mental/behavioral health)
- [ ] Therapist (SLP/OT/ABA)
- [x] Family
- [ ] Primary Care Clinician
- [ ] Other
- [ ] None

- [ ] I don't know

Have you had communication with the patient's primary care physician/nurse practitioner (PCP)?

- ( ) Yes
- (•) No

Resources

Resources (Check all that apply):

- [ ] Vocational Rehab
- [ ] Behavioral Therapy/ABA
- [ ] Autism Services through the Missouri Autism Project
- [ ] Speech Language Therapy (SLT)
- [ ] Physical Therapy (PT)
- [ ] Occupational Therapy (OT)
- [ ] Dept. of Mental Health/ Division of developmental disabilities (Regional Office/SB40 Board/Case Management)
- [x] Developmental Disabilities Case Manager or support coordinator
- [ ] Mental Health Case Manager
- [ ] Juvenile Office
- [x] Children's Division (Child Protective Services/Foster Care)
- [ ] Community Mental Health Services
- [ ] Community Psychiatric Rehab
- [ ] Community Psychiatrist
- [ ] Social Security Disability (SSI)
- [x] Waiver Services
- [ ] None of the above
- [ ] Other

Waiver Type:

- ( ) Community Support Waiver
- ( ) Missouri Children with Developmental Disabilities Waver
- ( ) Partnership for Hope Waiver
- ( ) Comprehensive Waiver
- (•) Other

Other Waiver:

Developmental Disabilities waiver - working on children's mental health waiver

Comments:

Trauma/Abuse History

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

Comments:

prenatal exposure to alcohol, cocaine, heroine, and marijuana

Social History

Patient resides with:

Immediate family

Has legal custody of the patient:

Extended family member (e.g., grandparent, s

Have the rights of the biological parents been terminated?

- ◉ Yes
- ○ No
- ○ Unsure

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

Who lives in the home with the patient?

Who lives in the home with the patient?

- ☐ Mom
- ☐ Dad
- ☐ Stepmom
- ☐ Stepdad
- ☐ Sibling(s) aged 0-10
- ☐ Sibling(s) aged 10-18
- ☐ Grandparent(s)
- ☑ Extended family

- [ ] Friend/roommate
- [ ] Patient's significant other
- [ ] Patient's child(ren)
- [ ] Other

Check all that apply

List other significant caregivers that live outside the home (e.g., family, friends, grandparents, neighbor)

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 abuse	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Educational History

Grade in School:

No longer in Full-Time Education

Can the patient read?

- (•) Yes
- ( ) No

Does the patient have an IEP or 504?

- (•) IEP
- ( ) 504
- ( ) No
- ( ) Unknown

What additional school supports are they receiving?

Is the Patient Employed?

- ( ) Yes
- (•) No

Does the Patient go to an Adult Day Program?

- ( ) Yes
- (•) No

Legal History

Does the patient have a prior or current legal case?

- ( ) Yes
- ( ) No
- ( ) I don't know

Visit Details

Evaluation

What is/was the level of support needed for evaluation of:

	Completed with minimal to no patient distress	Completed with moderate patient distress	Completed with intense patient distress	Completed with patient restraints (chemical or physical)	Unable to complete due to patient distress	Not attempted
Vital signs	○	○	○	◉	○	○
Physical exam	○	○	○	◉	○	○
Labs	○	○	○	◉	○	○
Blood work	○	○	○	◉	○	○
Imaging	○	○	○	◉	○	○
Procedures (e.g., IV placement, sutures, casting, etc)	○	○	○	◉	○	○
Medication administration	○	◉	○	○	○	○
Waiting between steps	○	○	◉	○	○	○
Transitions between steps	○	○	◉	○	○	○
Other	○	○	○	○	○	○

Level of support needed for:

	No support needed	Minimal	Moderate	Significant	Not applicable
Toileting	○	○	◉	○	○
Self-care (e.g., teeth brushing, bathing)	○	○	◉	○	○
Sleeping	○	◉	○	○	○
Eating	○	◉	○	○	○
Caregiver availability	○	○	○	○	◉
Safety	○	○	◉	○	○

Disposition Plan

- ○ Home
- ○ Medical floor
- ○ Psychiatric floor
- ◉ Outside location
- ○ Boarding (no placement options)
- ○ Other

Was the patient admitted to an inpatient medical floor?

◉ Yes ○ No

If yes, please specify:

- ○ General pediatrics floor
- ○ General adult medicine floor
- ○ Intensive care unit
- ◉ Integrated medical/psychiatric unit

What is/was the patient's length of stay?

- ○ Less than 24 hours
- ○ 1-3 days
- ○ 4-7 days
- ○ 8-14 days
- ○ 15-21 days
- ◉ 22-60 days
- ○ More than 60 days

Length of stay

- ○ Expected length for acute medical condition
- ○ Expected length for acute psychiatric condition
- ◉ Longer than expected
- ○ Shorter than expected

Please select all that apply:

- ☑ Discharge placement unavailable
- ☑ No space in next placement
- ☑ No option for next placement
- ☑ Family preference unavailable

Caregiver/Family preference:

- ◉ Perceived unsafe to discharge
- ○ Placement options unacceptable

Assessment/Evaluation/Treatment Challenges:

- ☐ Patient tolerance (e.g., need to space procedure timing, IV vs oral med delivery)
- ☑ Patient behavior prolonged stay (e.g., refusals, aggression or self-harm)
- ☑ Staffing access prolonged stay (e.g., 1:1 support, sedation for procedures)
- ☐ Equipment availability (e.g., protective equipment needs, specialized spaces)

What questions would you like help with related to this case?

1)

This patient is actually discharging today (yay!) but I would love it if we could talk through potential staff support throughout this case. She did significantly better when admitted (vs. living in the ER), but our hospital system typically does not allow autistic patients to be admitted.

2)

Consultation around med management when in the ER - since admitted, they have significantly reduced her meds, but when in the ER asked for an allowance to go above the recommended dosages for some meds/multiple antipsychotics, etc.

3)

Form Status

Complete? Complete