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: MOADD076

Presenting Provider: Jennie Koehler

Role of presenter:
* must provide value

Autism Resource Specialist

Co-Presenter Name(s) and roles:

Satrena Murray -Transition and Assessment Coordinator

Presentation Date: 2024-04-17 Y-M-D

Please answer the following questions about your clinic or agency:

What type of Clinic/Facility/Care Provider are you? IDD community service provider

Clinic/Facility Name: eitas-Developmental Disability Services of Jacks

Clinic/Facility City: Kansas City

Clinic/Facility Zip Code: 64138

Clinic/Facility Phone Number: (816)363-2000

Clinic/Facility Fax Number:

Demographic Information

Gender:

○ Male ◉ Female ○ Non-binary ○ Other

Person Age: 12 (Yrs)

10 (Mos)

Funding Type for person's services: Medicaid

Insurance Company: MO Healthnet

Race: Multi-racial

Ethnicity: Not Hispanic/Latino

What concerns would you like help with for this person?

Please list up to three concerns:

1)

Behaviors-communicating big emotions appropriately and effectively. Minimizing/eliminating aggressive behaviors.

2)

Elopement/safety awareness--(no stranger danger)

3)

Attention span/Increasing her attention span

Case Intervention Details

Please list some strengths of this person:

Super funny personality, amazing at art, can express complex stories through art/pictures, loves to sing and has a great singing voice.

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

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

The following plans are in place:

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

Communication Ability and Sensory Concerns

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

Autism
ADHD
Disruptive Mood Dysregulation disorder
Aggressive disorder
Depression (flat affect, not a typical depression)

What are the substantial functional limitations?

- [x] Receptive and Expressive Language
- [x] Self-Care
- [x] Learning
- [ ] Mobility
- [x] Self-direction
- [x] Capacity for Independent Living
- [x] 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

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

Severity Level of Sensory Concerns:

○ Minimal ○ Moderate ◉ Severe

Additional Comments:

She has history of self-harm.

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):

She has attempted to push a peer out a 2 story window, when alleged that peer was saying/doing mean things to a friend. Hit a little girl with baseball bat in an verbal confutation, when she was younger (10) another girl and her were auguring over a colored pencil and told the individual to go kill herself so the individual took the pencil to her neck.

Please describe how the person is aggressive:

Physically harming other by biting, kicked, hit, pushing

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

◉ Yes ○ No ○ N/A

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

◉ Yes ○ No

Date of functional behavior assessment:

Name of provider who completed the functional behavior assessment:

Please provide a brief summary of the functional behavior assessment report:

Unknown--in the last 2-3 years

If there were successful interventions put in place following the functional behavior assessment, please briefly describe:

ABA therapy--"were getting somewhere but then moved"

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

○ Yes ◉ No

Additional Comments:

Mom feels that had they not had to stop ABA due to the move that the individual would be further along.

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
ADHD
Disruptive Mood Dysregulation Disorder
Sensory dysregulation
Anxiety/depression
Aggressive Disorder
Motor Delays

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

Family, Individual and Group Therapy at her currently residential treatment
Anticipating that this will continue upon discharge

Frequency type (e.g, weekly, monthly)

weekly

Age when started:

(Yrs)

Reason for treatment:

residential teatment

Is it helping?

No

Comments:

She may not be getting full affect from the therapy

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.

Medical/Psychiatric History

Please list all diagnoses or illnesses:

Diagnosis/Illness:

Please list current medications and supplements:

Medication:

Additional medications:

Currently: Seroquel
Intuniv
Concerta
(an antidepressant)
Melatonin is no longer being taken due to the Seroquel

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
- [x] Insomnia/Sleep concerns
- [ ] Trouble Swallowing
- [ ] Stomach ache/pain/reflux
- [ ] Staring Spells
- [ ] Dental carries/pain
- [ ] Diarrhea
- [ ] Chronic Ear Infections
- [ ] Headaches
- [x] 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:

Yes for her IEP.

Intelligence testing

◉ Yes ○ No ○ Unknown

Results:

IQ on her current residential placement (January 2024) 84%

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

Is falling asleep a problem?

◉ 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

Is this a problem?

○ No ○ Rarely ◉ Sometimes ○ Usually

Comments:

Due to medication, and having difficulty staying awake and functioning

Trauma/Abuse History

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

Comments:

N/A

Social History

This person resides with: Residential Placement

Please indicate the relationship the legal guardian has with this individual. Mother-homevisits

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

How many people live in the home *not* including this person? 4

How many residents live with this person?

How many staff work in the home?

How many staff work with this person at a time?

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

Likes to call grandparents
Older brother that just started building relationship with

Doesn't have a relationship with bio father --this is his choice

Additional Comments:

N/A

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:

Depression for above marked

Educational History

Grade in School: 7th

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

Explain:

Lower academic level for both marked

Legal History

Does this child have a prior or current legal case? No

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)
- [x] Regional Office/SB40 Board (Dept. of Mental Health)
- [ ] Juvenile Office
- [ ] Children's Division
- [ ] Community Mental Health Services
- [ ] Community Psychiatric Rehab
- [ ] 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
- [ ] Weekly
- [ ] Do no communicate
- [x] Other

Please Identify Time Frame:

As needed

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

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

Please Identify Method:

As needed

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:

Effectively having the resources to best support the individual safely based on her support needs

Additional Comments:

Form Status

Complete?	Complete