Behavior Solutions In Hospitals Case Presentation

Response was completed on 04/22/2024 11:57am.

Record ID	2

ECHO Autism: Behavior Solutions in Hospitals

Case Discussion Form

Rena Sorensen, PhD; Rachel Brown, MD; Kristin Koehn, MD; Alicia Curran, BS, Grad Cert; Melinda Odum, LCSW

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:

BSIH18

Presenter Name:

* must provide value

Stephen Corley

Phone Number:

* must provide value

(233) 285-5479

Co-Presenter Name(s):

Presentation Date:

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

Where do you provide service?

* must provide value

- [x] Psychiatric Inpatient Unit
- [ ] 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)
- [ ] Free standing Children's Hospital
- [ ] Free standing Psychiatric Hospital
- [x] Hospital within a Hospital (peds within adult hospital, psychiatric hospital within a main hospital)
- [ ] Other

City:

* must provide value

Sunyani

State:

* must provide value

Not US-based

Zip/Postal Code

* must provide value

1908

Country:

* must provide value

Ghana

What services are available at your facility?

- [ ] Child Life
- [x] Behavior Crisis Team

- [ ] 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

- [ ] 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
- [x] Personal protective padding
- [ ] Hair ties
- [x] Room staff
- [ ] Other
- [ ] 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

What type of professionals are on this safety team?

* must provide value

- [x] Nursing
- [ ] Physician
- [x] Security
- [ ] Child Life
- [ ] Social Work
- [ ] Psychiatry
- [ ] Other

Check all that apply

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

9

Insurance:

* must provide value

- [ ] None
- [ ] Medicaid
- [ ] Medicare
- [x] 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?

Which other languages are spoken in the home?

- [x] 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

3

Acute medical presenting issue(s)

* must provide value

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

Check all that apply

Acute psychiatric/behavioral presenting issue(s)

* must provide value

- [x] Self-harm
- [ ] Suicidal thoughts
- [ ] 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
- [x] Facial expressions
- [ ] Verbalizes pain
- [ ] Hurting self/self-injury
- [ ] Aggression to others
- [x] Changes in behavior
- [ ] Decreased frustration tolerance
- [ ] Gets quiet/shuts down
- [x] Shaking/rocking
- [ ] Changes in breathing
- [ ] Communicates pain using identified form of communication
- [ ] 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

Who is the support person that helps the patient communicate?

- (•) Mom
- ( ) Dad
- ( ) Sibling
- ( ) Spouse
- ( ) Direct support provider
- ( ) Other

Is the support person present and able to provide the necessary support?

- (•) Yes
- ( ) No
- ( ) I don't know

Comments about communication

Support Needs Assessment

Sensory Sensitivities

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

Check all that apply

Level of Sensory Sensitivities:

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

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

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

Check all that apply

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

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

Check all that apply

How does the patient take medications?

- [ ] Swallows pills
- [ ] Chews pills
- [x] 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
- [ ] Short attention span
- [x] Hyperactivity
- [x] Obsessive-compulsive
- [x] Aggressive towards others
- [ ] Unusual or excessive fears
- [ ] Depression
- [ ] Defiant
- [x] Self-injury (e.g., head banging, head punching, biting, scratching, cutting, picking, etc.)
- [ ] Irritability/Moodiness
- [ ] Hallucinations
- [x] Food seeking
- [ ] Pica (i.e., eating non-food items)
- [ ] Public Masturbation
- [ ] Sexualized behaviors
- [ ] Property destruction
- [ ] Fascination with water
- [ ] Elopement/Wandering
- [ ] Impulsivity

- [ ] Homicidal concerns
- [ ] Suicidal concerns
- [x] Involuntary movements
- [ ] Other
- [ ] None

Check all that apply

What triggers interfering behavior(s)?

* must provide value

- [ ] Unexpected changes
- [ ] Transitions
- [ ] Fear
- [ ] Pain
- [ ] Non-preferred tasks
- [x] Lack of communication
- [ ] Interrupting impulsive behaviors
- [x] Interrupting obsessive/compulsive behaviors
- [ ] Illness
- [x] Anger
- [x] 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
- [ ] Home Staff
- [x] Strangers
- [ ] Outpatient Clinician
- [ ] 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

when she listens to music

What does the staff need to know to stay safe?

* must provide value

Having safety equipment

Comments:

Assessing the Patient's History

Please check all of the following that apply:

- [ ] Seizures
- [ ] Heart Problems
- [ ] Constipation
- [ ] Nausea/Vomiting
- [ ] Vision Changes
- [ ] Fever
- [ ] Trouble Swallowing
- [ ] Stomachache/pain/reflux
- [ ] Staring Spells
- [ ] Dental caries/pain
- [ ] Diarrhea
- [ ] Chronic Ear Infections
- [ ] Headaches
- [ ] 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
- [x] Group Therapy
- [x] Individual Therapy
- [x] Family Therapy
- [x] Cognitive-Behavioral Therapy
- [x] Play-Based Therapy
- [x] 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
- [ ] Sleep
- [ ] Constipation
- [ ] Allergies/Asthma
- [ ] 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
- [x] Fluoxetine (Prozac)
- [x] Focalin
- [ ] Focalin XR
- [ ] Guanfacine (Intuniv/Tenex)
- [ ] Lisdexamfetamine (Vyvanse)
- [ ] Metadate
- [ ] Metadate CD
- [ ] Methylphenidate
- [ ] Mixed dextroamphetamine salts
- [ ] Propranolol
- [ ] Quillivant
- [ ] Risperidone (Risperdal)
- [ ] Ritalin
- [ ] Seroquel
- [ ] Sertraline (Zoloft)
- [ ] Strattera (Atomoxetine)
- [ ] Other

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

* must provide value

- ( ) Yes
- (•) No

Outpatient Care Team

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

* must provide value

- [ ] School staff
- [ ] Support coordinator
- [x] Psychiatrist
- [x] Therapist (mental/behavioral health)
- [ ] Therapist (SLP/OT/ABA)
- [x] Family
- [x] 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
- [x] Support coordinator
- [ ] Psychiatrist
- [ ] Therapist (mental/behavioral health)
- [ ] Therapist (SLP/OT/ABA)
- [x] Family
- [x] 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

How did you communicate with the PCP?

- [ ] Phone call
- [ ] Text
- [ ] Automated notification through EMR
- [x] In-person interaction
- [ ] Other

Resources

Resources (Check all that apply):

- [ ] Vocational Rehab
- [ ] Behavioral Therapy/ABA
- [x] 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)
- [ ] Developmental Disabilities Case Manager or support coordinator
- [ ] Mental Health Case Manager
- [ ] Juvenile Office
- [ ] Children's Division (Child Protective Services/Foster Care)

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

Comments:

Trauma/Abuse History

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

Comments:

Social History

Patient resides with:

Extended family

Has legal custody of the patient:

Mother

How many people live in the home *not* including the patient? 3

Who lives in the home with the patient?

Who lives in the home with the patient?

- [x] Mom
- [ ] Dad
- [ ] Stepmom
- [ ] Stepdad
- [ ] Sibling(s) aged 0-10
- [ ] Sibling(s) aged 10-18
- [x] 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:

5th

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?

What best describes the patient's current education program?

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

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

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

1)

2)

3)

Form Status

Complete? Complete