ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

Agenda

Zoom link to join from PC, Mac, iOS or Android**:** https://echo.zoom.us/j/156261634

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Zoom Meeting ID: 156 261 634

For attendance, purposes please text the following code: SUHWUD to 608-260-7097

Session Date: Friday August 16, 2019

Didactic Topic and Presenter:
An Overview of Fetal Alcohol Spectrum Disorders in the Adult Population
by Lindsey Peterson, MS, CRC Deputy Title IX Coordinator for Precollege and Youth Programs—UW-Madison

Content Experts:
Ritu Bhatnagar, MD and Susan Mindock, CSAC; and Sheila Weix, MSN, RN, CARN

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Case Presentation & discussion
  - Presenter: Sheila Weix, MSN, RN, CARN
- 1:15 PM: Didactic Presentation
  - Presenter: Lindsey Peterson, MS, CR
- 1:30 PM End of Session

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Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2018-2020

An Overview of Fetal Alcohol Spectrum Disorders in the Adult Population
Friday August 16, 2019
Lindsey Peterson, MS, CRC

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Physicians, Physician Assistants, Nurses, Social Workers, Pharmacists and Counselors.

Objectives:
As a result of this educational regularly scheduled series, learners will be able to:

1. Review appropriate opioid prescribing and monitoring practices.
2. Participate in office-based management of substance use disorders.
3. Seek, with greater frequency, overdose prevention education.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of substance use disorders.

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Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Lindsey Peterson, Presenter	No relevant financial relationships to disclose	No
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair	No relevant financial relationships to disclose	Yes
Chris Nicholas, Content Expert, Psychology-SUD/Mental Health Counselor	No relevant financial relationships to disclose	Yes
Paul Hutson, Content Expert, Pharmacy	Consultant for Projections Research Inc.	Yes
Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	No
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse	No relevant financial relationships to disclose	No
Eun Ha Kim, Content Expert	No relevant financial relationships to disclose	No
Dean Krahn, Content Expert	No relevant financial relationships to disclose	Yes
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

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CONTINUING EUDCATION INFORMATION:

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Pharmacists and Pharmacy Technicians must enter their NABP number in their profile in order to receive credit.

2019 Universal Activity Number (UAN)
JA0000358-9999-19-002-L04-P
JA0000358-9999-19-002-L04-T

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Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1. Date: 8/16/2019
2. Presenter Name: Sheila Weix
3. Presenter Organization: Family Health Center A&DRC – Marshfield Clinic Health System
4. ECHO ID:
5. Have you presented this patient during this teleECHO clinic before? Yes (3/2019)
6. PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Follow-up presentation: Does anyone have any additional suggestions?

Patient Demographic Information:

7. Age: 35
8. Sex: F
9. Education/Literacy: GED/HSED
10. Income source: Unemployed x 3 years' d/t medical issues; Relies on family for financial resources
11. 1Social Factors/History: Divorced x1; Currently in relationship; Has teen-aged son; Multiple medical diagnoses resulting in immersion in healthcare

12. **Substance Use History:**

    Opioids since age 25 related to medical diagnoses – using medical opioids
    Marijuana since age 27 related to seeking relief of nausea, vomiting, abdominal pain – using edibles and vaping

13. **Consequences of Substance Use:**
    - Social/occupational/educational: Yes
    - Physical (including evidence of tolerance/withdrawal): Yes

14. <u>Interventions that have been tried:</u> 25 hospitalizations in 2018 on fentanyl patches with episodes of uncontrolled pain leading to hospitalization;
Received IV morphine, in addition to po tramadol and transdermal fentanyl when hospitalized
Several psychiatric consults while hospitalized; some involvement in counseling over the years, but limited engagement

Entered A&DRC services 1/23/2019 with visits 1/23, 2/1, 2/6 to complete assessments and induction 2/20/19. 2 hospitalizations during the process with discontinuation of pain meds in hospital and transport of patient directly to A&DR for induction 2/20/19.

5 hospitalizations in 2019. 3 hospitalizations before entering A&DRC, 2 hospitalizations since with most recent 3/12/2019

Currently in individual SUD counseling with buprenorphine combination product in qid divided doses to address OUD and pain

"Crisis plan" developed with PCP to allow outpatient IV fluids and Zofran when patient experiences nausea/vomiting that previously lead to hospitalization. 1x in past 2 months

Currently having work-up for sleep issues and restless legs

15.

Current Addiction and Mental Health-related Medications:	Medical/Behavioral Health Diagnosis:
• Cymbalta (duloxetine) • Seroquel (quetiapine), • Gabapentin, hydroxyzine, • Pamelor (nortiptyline), • Buspirone • Buprenorphine-Naloxone (Suboxone®) Sublingual 4-1 mg Film Disp: 28 Film(s) Refills: 0 Sig: 1 Film(s) sublingually four times daily for 7 day course	• Abdominal pain, chronic, generalized • Anxiety • Depression • Diabetes mellitus • Dyslipidemia • Gastroparesis • Hypothyroidism • Iron deficiency anemia • Lactose intolerance • Migraines • Opioid Use Disorder • Cannabis Use Disorder • Fibromyalgia. • Chronic Back Pain.

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16.

Patient Strengths/protective factors:	Risk factors:
• Has continued to engage with providers, even when very angry • Is having dental work done • Is following through with Physical Therapy • Has engaged with the plan of care • Family	• History of abuse • Long-term medical issues • Recent appearance of etoh

17. Labs (as indicated), include summary of urine testing or last urine drug screen results:

Prescribed Dose at time of UDT: 12 mg daily (prescribed) reports use of 0 today, 8 mg yesterday and 12 mg prior day.

Pt currently on MAT, findings:

(*) MAT APPROPRIATELY POSITIVE: Positive for the identified treatment medication with metabolites levels consistent with prescribed dose (Female 12 mg dose norms).

(*) CONCERN: POSITIVE for MARIJUANA metabolite THCA with ratio of 3.2, which is somewhat reduced. The pt continues report ongoing use, last time this morning.

Consecutive Reasonable UDTs: 0

Consecutive Fully Appropriate UDTs: 0

18. Patient Goals/Motivations for Treatment:

Wants to receive medication and work through her mental health problems

19. Proposed Diagnoses:

See above

20. Proposed Treatment Plan:

Recognition of accomplishments since entering services

Continued work on mj use

Further work around trauma background

Normalization – “life outside of being a patient”

By initialing here _smw____ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

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DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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An Overview of Fetal Alcohol Spectrum Disorders in the Adult Population

Lindsey Peterson, MS, CRC

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Project ECHO University of Wisconsin

Terminology

- Fetal alcohol spectrum disorders (FASDs): an umbrella term describing the range of effects that can result from prenatal alcohol exposure – NOT a diagnostic term
- Fetal alcohol syndrome (FAS): a medical diagnosis, usually made by a physician

Umbrella of FASD

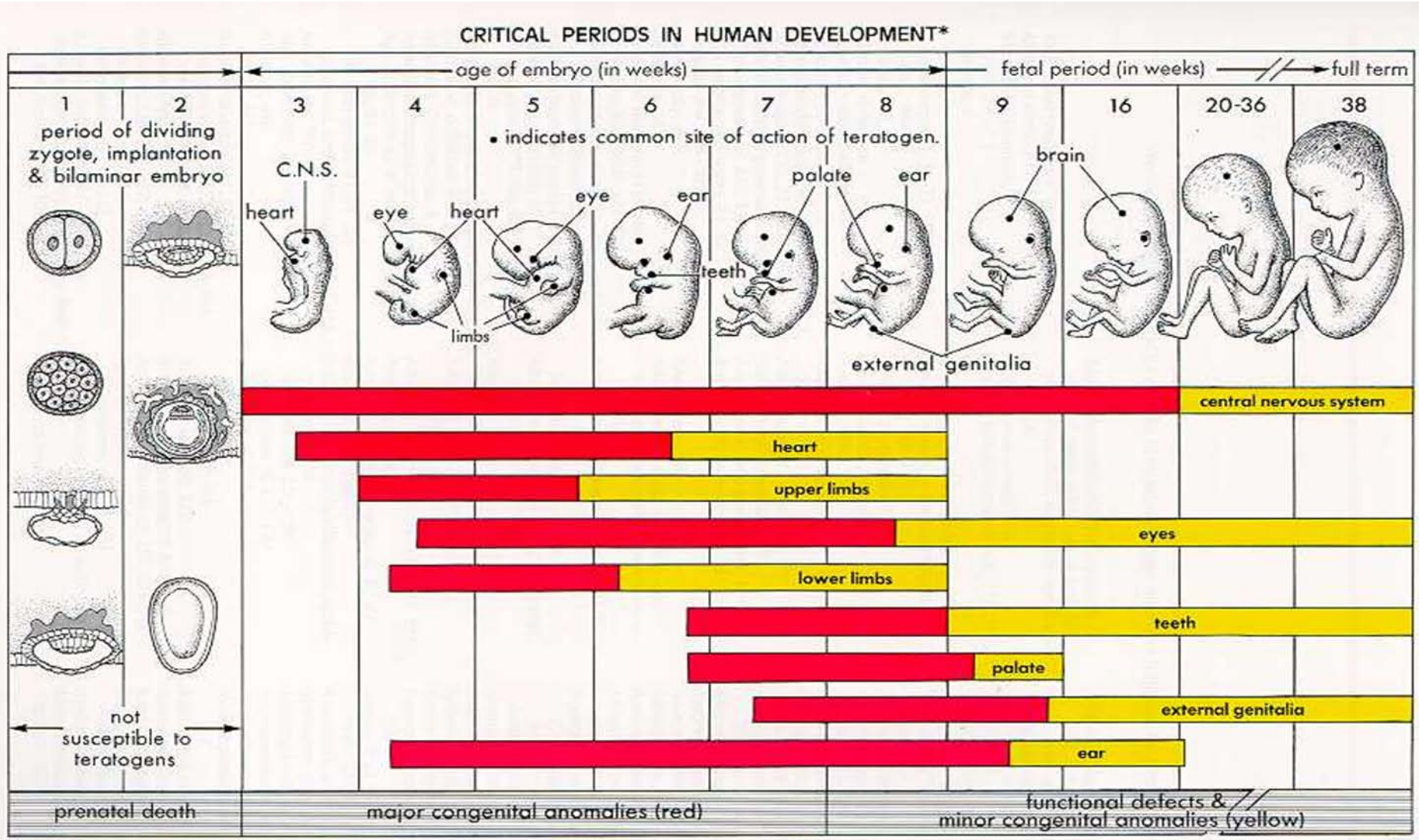
- Fetal Alcohol Syndrome (FAS)
- Partial Fetal Alcohol Syndrome (pFAS)
- Alcohol-Related Birth Defects (ARBD)
- Alcohol-Related Neurodevelopmental Disorder (ARND)

DSM – 5

- Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure 315.8 (F88)
- Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (Section III)

Alcohol and Pregnancy

- About 1 in 20 pregnant women drink excessively before finding out they are pregnant
- 7.6% of pregnant women use alcohol and 1.4% binge drink
- No known safe amount of alcohol or safe time to drink alcohol during pregnancy
- There is a wide range of disabilities due to prenatal alcohol exposure, from mild to severe
- Of all drugs of abuse, alcohol causes the most serious and long-lasting neurobehavioral damage



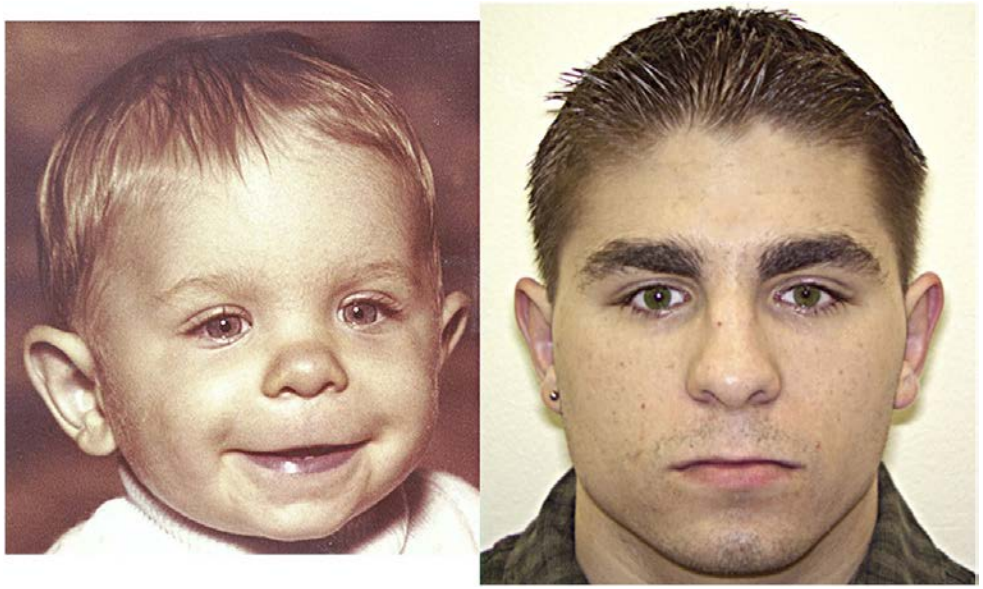
* Red indicates highly sensitive periods when teratogens may induce major anomalies.

Incidence and Prevalence

- The range of FASDs are more prevalent than Autism Spectrum Disorders (ASD) and Down Syndrome
- Studies using in-person assessment of school-aged children identified 6-9 out of 1,000 children with FAS
- FAS is the “tip of the iceberg”
  - Estimated rates for the full range of FASDs are as high as 24 to 48 of 1,000 school-aged children (2.4 – 4.8% of the population) (May et. al., 2014)
- Majority undiagnosed

Implications

- Individuals affected by prenatal alcohol exposure can have a range of serious, lifelong problems including physical, cognitive, behavioral and social deficits



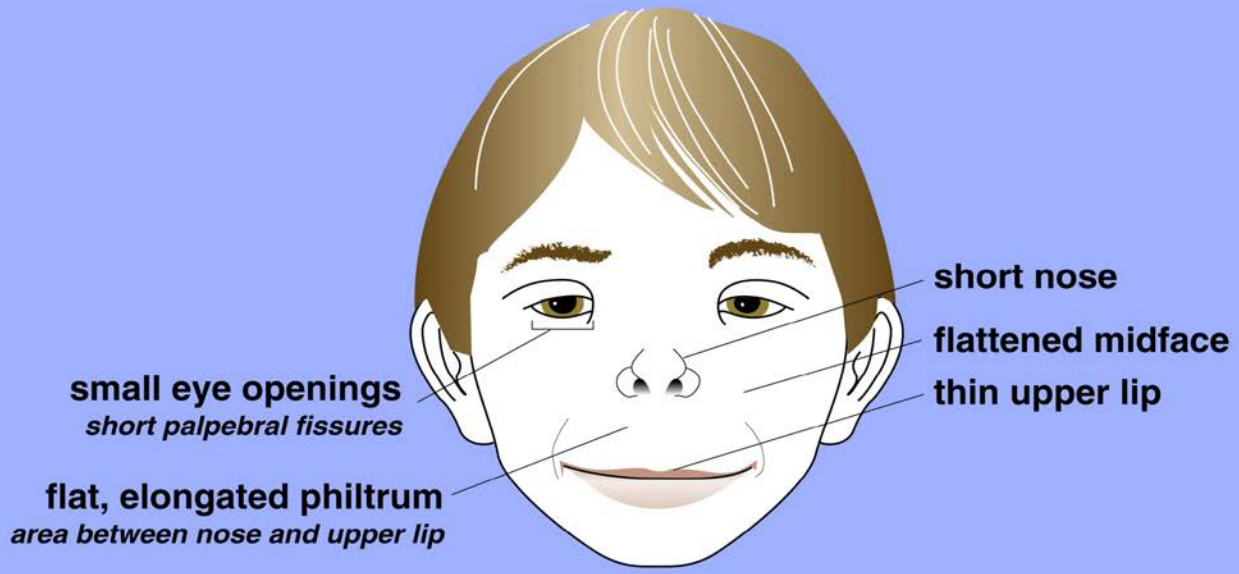
Young man presenting with the 3 facial features of FAS (small eyes, smooth philtrum, and thin upper lip) at 2 years of age and 20 years of age. Legend written by Susan Astley, PhD. © 2015, Susan Astley PhD, University of Washington.

FAS Diagnostic Criteria

- The effects of alcohol on the developing fetus depend on timing, amount, and frequency of alcohol consumption
- The following are required to confirm a diagnosis of FAS:
  - Specific facial features (small palpebral fissures, smooth philtrum, thin upper lip)
  - Growth retardation (small height/weight)
  - Central nervous system abnormalities (i.e., reduced brain size)

A documented report of prenatal alcohol exposure is NOT required for a diagnosis of FAS

Discriminating Features in FAS in Young Child



Partial FAS (pFAS)

- Two or more specific facial features, *and*
- One of the following:
  - Pre and/or postnatal growth retardation
  - Evidence of deficient brain growth or structural abnormalities
  - Evidence of cognitive/behavioral abnormalities, inconsistent with developmental level that can't be explained by genetics/family/environment alone

A documented report of prenatal alcohol exposure is NOT required

Alcohol-Related Birth Defects (ARBD)

- Confirmed prenatal alcohol exposure
- Two or more specific facial features
- At least one associated congenital structural deficit (i.e., supination/pronation of the wrist and forearm)

Alcohol-Related Neurodevelopmental Disorder (ARND)

- Confirmed prenatal alcohol exposure
- At least one of the following:
  - Evidence of deficient brain growth or structural abnormalities, *and/or*
  - Evidence of cognitive/behavioral abnormalities, inconsistent with developmental level, that can't be explained by genetics/family/environment alone

Brain Structures Affected

- Prenatal alcohol exposure affects all regions of the brain
- Areas that are particularly susceptible include:
  - Corpus callosum: communication between two hemispheres of the brain
  - Frontal lobe: control emotional responses, processing of humor, expressive language; responsible for abstract thinking; involved in processing information and deciding how to act
  - Hippocampus: memory, learning, emotion
  - Amygdala: fear, stress, anxiety, anger, aggression

Cognition

- Specific learning disabilities
- Poor academic achievement
- Discrepancy between verbal and nonverbal skills
- Slowed movements or reaction to people and stimuli

Executive Functioning

- Poor organization and planning skills
- Concrete thinking
- Lack of inhibition
- Poor judgement
- Inattention
- Memory problems
- Hyperactivity

Motor Functioning

- Delayed motor milestones
- Clumsiness
- Balance problems
- Tremors
- Poor dexterity

Social Skills

- Lack of stranger fear
- Vulnerability to being taken advantage of
- Immaturity
- Superficial interactions
- Inappropriate choice of friends
- Increasing social difficulties with age
- Difficulty comprehending other's feelings

Common Co-Occurring Disorders with FASD

- Sensory integration disorder
- Reactive attachment disorder
- Attention-deficit/hyperactivity disorder
- Traumatic brain injury
- Borderline personality disorder
- Depression
- Substance use disorders

Possible Misdiagnoses for Individuals with FASD

- ADHD
- Oppositional Defiant Disorder
- Conduct Disorder

Structural Support

- Provide consistent routines and consequences (if you do X, then Y will happen)
- Provide frequent, short breaks
- Modify timeframes
  - Increased time for transitions and changes
  - Increased time to process and respond to questions
- Concepts of dependency and enabling as ‘negative’ terms should be re-considered
  - Taking someone to their appointment, checking on them regularly, or filling out forms with them may be what they need

D. Dubovsky, 2016

Educational Strategies

- Use short and simple sentences
- Teach one concept at a time with memory strategies
- Use concrete language and refrain from using abstract language and idioms
- Ask the client to repeat information they just heard
  - Caution: A higher verbal IQ than overall IQ is common, so they might verbalize a concept without being able to fully understand it
- Repetition, repetition, repetition
  - Don’t assume they remember what you talked about yesterday

Counseling

- Focus on social skills
  - Area where many people with an FASD stumble
- Consider the insight of the client vs. actual behavior
  - Concrete vs. insight-oriented counseling (i.e., Motivational Interviewing is abstract and may not be as effective)
- Modify counseling to accommodate cognitive disability
  - Individual rather than group counseling
  - Provide reminders for upcoming appointments

Counseling, cont.

- Assist client to identify issues of importance
  - Don't expect generalization; teach in real environments (may require field trips to home, work, community)
  - Don't use examples that aren't relevant to the client
- Re-direct behavior if necessary
- Acknowledge anger, frustration or over-stimulation
- Limit staff changes whenever possible, and prepare the client for changes when they do occur
- If you joke with the client, let them know you are joking, and point out when others are joking as well

Approaches to Modify Behavior

- Remember that behavior may be related to (or exacerbated by):
  - Lack of sleep
  - Sensory difficulties
- Use multiple senses (touch, smell, sound) in addition to verbal approaches
  - Art therapy, etc.
- Designate a mentor for the individual to go to when they have a question or do not know what to do
  - Role-playing situations and modeling behavior can be helpful

Approaches to Modify Behavior, cont.

- If consequences need to be used, they should be immediate, related to what occurred, and finished preferably within the same day
- Any time you tell someone “you can’t…” you must also say “but you can…”

D. Dubovsky, 2016

Strengths-Based Approach

- Identify strengths, abilities, and work to build upon them
- Point out small accomplishments frequently
- Consistently tell the person what they do well and what they are good at

D. Dubovsky, 2016

Citations

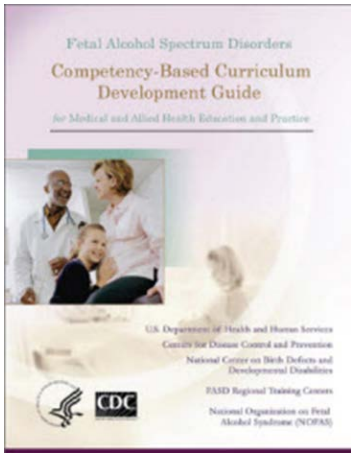
The material shared in this presentation is from two federal sources. More information on alcohol and FASDs is available from both.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Website: www.niaaa.nih.gov

Centers for Disease Control and Prevention

Website: www.cdc.gov



The FASD Competency-Based Curriculum Development Guide for Medical and Allied Health Education and Practice