

UVM Project ECHO: Adult Complex Mental Health

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- RECORDING OF SESSION TO BEGIN



Agenda

- Introductions
- Objectives
- Didactic Presentation (~20-30 min)
- Case presentation
 - Clarifying questions
 - Participants – then faculty panel
- Discussion
- Recommendations
- Summary
- Closing Announcements
 - Submission of new cases
 - Completion of evaluations



Series Objectives

Learning objectives for this ECHO series include the ability to:

- Enhance diagnostic skills in patients with complex mental health issues
- Incorporate new treatment strategies into management of common but challenging mental health disorders
- Improve the care that patients with mental health issues receive in the primary care setting



CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1.5 AMA PRA Category 1 Credits.

UVM CMIE is accredited by the American Nurses Credentialing Center (ANCC) to provide CE for the healthcare team. This program has been reviewed and is acceptable for up to 1.5 Nursing Contact Hours.

As a Jointly Accredited Organization, The Robert Larner College of Medicine at the University of Vermont is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The University of Vermont maintains responsibility for this course. Social workers completing this course receive 1.5 continuing education credits.

This activity was planned by and for the healthcare team, and learners will receive 1.5 Interprofessional Continuing Education (IPCE) credit for learning and change.

Participants should claim only the credit commensurate with the extent of their participation in the activity.

CME Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.

Update on Eating Disorders

Kathy Mariani, MD MPH
UVM Larner College of Medicine
Department of Family Medicine



Session Objectives

By the end of this activity, the learners should be able to:

- Have increased confidence in screening and diagnosis of eating disorders
- Have increased confidence managing patients with disordered eating
- Increase knowledge of eating disorder resources and when to refer to higher level of care



Issues for Primary Care Providers:

- What are some of the early signs that we might see in patients presenting for other reasons?
- How can we differentiate between unusual food preferences and eating behaviors of concern?
- Are there cultural differences we may see in our populations that could be confused with eating disorders?
- What are the current treatments and when do we refer to higher level of care?
- Who should be part of the multidisciplinary team?



What is the data?

- Estimated Prevalence Across Lifespan:
 - Anorexia: 0.9% female and 0.3% male
 - Bulimia: 1.5% female and 0.5% male
 - Binge Eating Disorder: 3.5% female and 2% male
- Males make up 25% of cases of ED but often undiagnosed
- Second highest mortality rate second to opioid addiction. Crude mortality rates were 4% for anorexia nervosa; 3.9% for bulimia nervosa;
- 1 in five of deaths related to suicide



Screening for Eating Disorders

- All ages, race, and socioeconomic levels at risk
- High risk groups:
 - Sexual minority
 - Transgender - up to 16 times higher risk
 - Adolescents with chronic medical diseases such as diabetes
 - Athletes-Relative Energy Deficiency of Sports (new name for Female Athlete Triad)



The SCOFF questions*

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14 lb) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

ESP Eating disorder Screening in Primary care

- Are you satisfied with your eating patterns? (A “no” to this question was classified as an abnormal response).
- Do you ever eat in secret? (A “yes” to this and all other questions was classified as an abnormal response).
- Does your weight affect the way you feel about yourself?
- Have any members of your family suffered with an eating disorder?
- Do you currently suffer with or have you ever suffered in the past with an eating disorder?



Talking about Eating Disorders:

- Consider “recommended weight range” versus Ideal Body Weight
- Weight “restoration” not weight gain
- Blind weight
- Communication with families
- Remember the classic question
Is there anything else?



Diagnosis updates with DSM5

- Addition of Binge Eating Disorder (BED) and Avoidant Restrictive Feed Intake Disorder (ARFID)
- Removal of Eating Disorder Not Otherwise Specified (EDNOS)
- Decrease in frequency of behaviors in criteria for bulimia
- Amenorrhea and specific percentiles removed for diagnosis of anorexia



Avoidant/Restrictive Feed Intake Disorder (ARFID)

- Avoiding and restricting food due to:
 - Lack of interest
 - Taste, texture or smell issues with food
 - Fear of food after negative experience such as choking
 - Behavior leads to failure to meet nutritional needs
- As a consequence of restricting, dx requires one of these:
 - Weight loss, poor growth or failure to gain
 - Nutritional deficiency
 - Requires supplement feeding
 - Results in impaired psychosocial function
- Not due to lack of food available
- Not due to other mental health or medical condition
- Not due to anorexia, bulimia or distorted body image



ARFID Treatment

- Very difficult to treat, may not respond to typical eating disorder programs
- Family Based Treatment
- Often lack of insight or concern of weight loss (overwhelming fear of eating)
- Dietician often plays role of “coach”
- Team communication very important
- Diagnosis difficult; over exercise may also exist



Typical patient with ARFID:

- Any age
- Not fearful of weight gain
- Not triggered by weight or scale
- Lacks appetite
- Describes fear of eating, fear of choking, takes excessive amount of time to eat
- No excessive exercise
- Classic “picky” eater



Anorexia Nervosa-DSM-5 Criteria

- Restricted caloric intake relative to energy requirements, leading to significantly low body weight for age, sex, projected growth, and physical health
- Intense fear of gaining weight or behaviors that consistently interfere with weight gain, despite being at a significantly low weight
- Altered perception of one's body weight or shape, excessive influence of body weight or shape on self-value, or persistent lack of acknowledgment of the seriousness of one's low body weight



Anorexia Nervosa-DSM-5 Criteria

- Subtypes:
 - restricting type (weight loss is achieved primarily through dieting, fasting, and/or excessive exercise. In the previous 3 mo, there have been no repeated episodes of binge eating or purging);
 - binge-eating/purging type (in the previous 3 mo, there have been repeated episodes of binge eating or purging; ie, self-induced vomiting or misuse of laxatives, diuretics, or enemas)



Anorexia Nervosa-Treatment

- Nutrition and Psychotherapy including family
- Pharmacology
 - Olanzapine off label use evidence helps with weight restoration when not responding to first line
 - SSRI shows no significant benefit in reduction of AN symptoms
 - No benefit of, cyproheptadine, cannabinoids, lithium, zinc, omega-3 fatty acid supplementation, pre-meal benzo and testosterone



Bulimia

- Repeated episodes of binge eating characterized by both of the following:
 - Within a distinct period of time (eg, 2 h), eating an amount of food that is clearly larger than what most individuals would eat during a similar period of time
 - Repeated use of inappropriate compensatory behavior
- On average, the binge eating and compensatory behaviors both occur at least once a week for 3 months
- Self-value is overly influenced by body shape and weight



Bulimia

Mild: An average of 1 to 3 episodes of inappropriate compensatory behaviors per week.

Moderate: An average of 4 to 7 episodes of inappropriate compensatory behaviors per week.

Severe: An average of 8 to 13 episodes of inappropriate compensatory behaviors per week.

Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors per week.



Treatment for Bulimia

- First line medication Fluoxetine
- Second line: Sertraline, topiramate and if no response, tricyclic
- Consider trazadone
- Contraindicated or high risk: Stimulants, lithium, and bupropion



Binge Eating Disorder (BED)

- Recurrent episodes of binge eating
 - within a distinct period of time (eg, 2 h), eating an amount of food that is clearly larger than what most individuals would eat during a similar period of time including 3 or more of the following:
 - eating much more quickly than normal,
 - eating until uncomfortably full,
 - eating large amounts of food when not feeling hungry,
 - eating alone because of embarrassment at how much one is eating,
 - feeling guilty, disgusted, or depressed afterward
- Marked anguish is experienced regarding binge eating
- On average, the binge eating occurs at least once a week for 3 months
- The binge eating is not associated with the use of inappropriate compensatory behavior as in BN and does not occur only in the context of BN or AN



Binge Eating Disorder (BED)

Medication treatments may have more evidence than other eating disorders

- SSRI
- Lisdexamfetamine (Vyvanse) approved for binge eating but contraindicated if purging
- Topiramate (Topamax) off label
- Zonisamide (Zonegran) off label use

Other diagnosis:

- Atypical AN: all of the criteria for AN yet the individual's weight is within or above the normal range despite significant weight loss
- BN or BED (of low frequency and/or limited duration): All of the criteria, but behaviors occur less than once a week and/or for <3 mo
- Diabulimia- insulin restriction among people with diabetes
- Other specified feeding or eating disorder (OSFED)
- Purging disorder: recurrent purging behavior (eg, self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating with the intent to influence weight or body shape



Eating Disorder Complications

- Electrolytes-Dehydration; hypokalemia, hyponatremia;
- Neurologic-cognitive deficits; seizures
- Cardiac-Decreased cardiac muscle mass, arrhythmias, pericardial effusion; congestive heart failure; edema
- Hematologic-Leukopenia, anemia, thrombocytopenia,
- GI-Delayed gastric emptying, GERD, esophagitis; Mallory-Weiss tears; gastric rupture; laxative dependence
- Endocrine-Growth retardation; euthyroid; hypoglycemia/hyperglycemia; night sweats; bone loss
- GU/GYN-polyuria, nocturia, infertility, amenorrhea
- Dental-Dental erosions



Eating Disorder Complications

- Psychiatric-Depressed mood; OCD; anxiety; suicide, fatigue, poor focus

School and Home:

- Social isolation
- Family conflict
- Decreased athletic and academic performance



Multidisciplinary Approach

- Team members:
 - Psychotherapy
 - Dietician
 - Psychiatrist
 - Primary care provider
- Team meetings
- Collaboration
- Goals aligned
- Plan for weights
- Exercise plan



Higher level of Care: Out-Patient Treatment Options

- Intensive Out-Patient (IOP)-
 - Three to five days a week 2-4 hours a day
 - Currently in-person and virtual options
- Partial Hospitalization Program (PHP)
 - Daily all day
 - Usually in person, some provide housing

Higher level of Care: Indications for Residential Treatment

- Poor motivation for recovery
- Need for structure and supervision to prevent unhealthy behaviors
- Lack of a supportive family environment
- Absence of outpatient treatment options
- Outpatient interventions having been unsuccessful



Criteria for hospitalization

- <75% median BMI for age and sex
- Acute food refusal
- Uncontrollable binge eating and purging
- Acute medical complications
- Comorbid psychiatric or medical conditions
- Failure of outpatient treatment
- Arrested growth and development
- Hypothermia (body temp < 96F or 35.6C)
- Orthostatic increase in pulse (>20B/min)
- Orthostatic decrease in BP (>20mmhg)
- Severe bradycardia
- Abnormal EKG (prolonged QTc severe brady)
- Dehydration
- Electrolyte disturbance



Eating Disorder Resources

- [National Eating Disorder Association \(NEDA\)](#)
- [ANAD](#)
- [Academy for Eating Disorders \(AED\)](#)
- [Renfrew](#)



Discussion and Q & A

Cases/HIPAA

DO NOT INCLUDE:

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #



The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.



Case Presentation Format

Case presentation from a participant (a *real-world case, from the field*)

Then

Clarifying questions about the case from group to case presenter

Then

Ideas, suggestions, recommendations from participants

Then

Ideas, suggestions, recommendations from ECHO faculty team

Then

Additional discussion, if any (All)

Then

Summary of case discussion (course director: Mark Pasanen, MD)



- RECORDING TO BE STOPPED FOR CASE PRESENTATION



- Add case slides

Questions and Discussion from the group....



The University of Vermont
LARNER COLLEGE OF MEDICINE
OFFICE OF PRIMARY CARE & AHEC PROGRAM



Prep for Next Session

Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.

SESSIONS ARE ON WEDNESDAYS FROM 12:00PM TO 1:30PM		
DATES	SESSION	DIDACTIC TOPICS (in addition to case review)
Jan 19	TeleECHO Session 1	Attention Deficit Disorder – Diagnosis (Sara Pawlowski, MD)
Feb 2	TeleECHO Session 2	Attention Deficit Disorder – Management (Sara Pawlowski, MD)
Feb 16	TeleECHO Session 3	Resistant Depression (Evan Eyler, MD)
Mar 2	TeleECHO Session 4	Management of Sleep Disruption (including menopause) and Impact on Mental Health (Jess Oehlke, MD)
Mar 16	TeleECHO Session 5	Role of Electroconvulsive Therapy (Evan Eyler, MD)
Mar 30	TeleECHO Session 6	Mental Health in Patients with Substance Use Disorders (Brady Heward, MD)
Apr 13	TeleECHO Session 7	Eating Disorders (Kathy Mariani, MD)
Apr 27	TeleECHO Session 8	Chronic Pain and Mood Disorders (Mark Pasanen, MD)
May 11	TeleECHO Session 9	Mental Health in the Elderly (Jennifer Hall, DO)
May 25	TeleECHO Session 10	Resistant Anxiety (Jessica O’Neil, DO)
June 8	TeleECHO Session 11	Bipolar Disease – Diagnosis (Suzanne Kennedy, MD)
June 22	TeleECHO Session 12	Bipolar Disease – Management (Suzanne Kennedy, MD)



Conclusion

- Slides are posted at www.vtahec.org
- Volunteers to present cases (this is key to the Project ECHO model)
 - Please submit cases to Mark.Pasanen@uvm.edu
- Please complete evaluation survey after each session
- Once your completed evaluation is submitted, CE information will be emailed to you.
- Please contact us with any questions, concerns, or suggestions
 - Mark.Pasanen@uvm.edu
 - Elizabeth.Cote@uvm.edu

