

WORKING DRAFT

ACADEMY FOR EATING DISORDERS CREDENTIALING TASK FORCE

CLINICAL PRACTICE RECOMMENDATIONS FOR RESIDENTIAL AND INPATIENT EATING DISORDER PROGRAMS

In response to family member concerns and a desire to promote basic standards to ensure high quality residential and inpatient and treatment for eating disorders, the Academy for Eating Disorders (AED) and the National Eating Disorders Association (NEDA) began collaborating in 2004 to develop clinical practice recommendations for residential and inpatient eating disorder program accreditation. This collaboration began with the formation of the AED Credentialing Task Force, and since its inception, a third main eating disorders organization, the International Association of Eating Disorder Professionals (IAEDP), has joined the collaboration. These organizations, along with many other stakeholders, including leaders in the eating disorders field and related professions, residential/inpatient treatment program directors, as well as recovered individuals and family members, have jointly worked to identify recommendations for best practices in the residential/inpatient treatment of eating disorders. The recommendations are intended for use in clinical governance and quality assurance and as a guide for credentialing of treatment programs and/or the development of key performance indicators. The task force also drafted a beginning work plan that assisted in the identification of accrediting bodies that would utilize these recommendations in a formal process of program accreditation.

The clinical practice recommendations for residential and inpatient eating disorder programs were developed for programs that offer eating disorder treatment to patients 24-hours per day, 7 days per week under the supervision of a licensed health care professional who has access to a licensed physician. The majority of recommendations apply to eating disorder residential and inpatient programs across the globe, while a number of recommendations include items that apply specifically to programs in the USA. The latter are italicized in the document. Since the intent was to render the recommendations informative to standards for best practices in health care systems inside and outside the USA, expert consultation from colleagues in other countries was obtained. These countries included Australia, Canada, and the United Kingdom.

The clinical practice recommendations are the product of a 2006 stakeholders meeting and three work groups that met from 2005-2006. A fourth work group focused on the development of a work plan to identify an accreditation body that would use the clinical practice recommendations to develop a formal program accreditation process in the USA. This work was done to advance development of accreditation programs in the USA but also with the idea that the work could inform others' efforts across the globe as they pursue accreditation for eating disorder residential and inpatient programs.

The AED Credentialing Task Force Chairperson and the work groups and their respective chairpersons who contributed to the clinical practice recommendations are noted below. The full list of AED Credentialing Task Force members, consultants, and Work Group Chairs and members is in Appendix A. This Appendix also includes the Co-chairs (William Davis PhD, USA and Mae Sokol MD, USA) and members of a fifth work group that addressed specialized protocol practice recommendations, e.g., treatment of physiological and psychological co-morbid conditions. These recommendations are not included in this document because it was deemed essential to first disseminate more general standards applicable across all eating disorder residential or inpatient programs. The child and adolescent-based recommendations also developed by work group V were integrated into work group I and II recommendations regarding assessment and treatment planning and delivery.

AED Task Force Chair: Mary Tantillo, PhD PMHCNS-BC FAED, USA

Task Force Work Group Chairs:

- I. Assessment and Treatment Planning: Joel Jahraus, MD, FAED, USA and Benita Quakenbush-Roberts, PhD, USA**
- II. Treatment Delivery: Jillian Lampert, PhD, MPH, RD, LD, FAED, USA and Craig Johnson PhD, FAED, USA**
- III. Quality Improvement and Outcome Measurement: Pauline Powers, MD, FAED, USA and Jim Mitchell, MD, FAED, USA**
- IV. Accreditation Work plan: Doug Bunnell, PhD, FAED, USA and Ovidio Bermudez, MD, FAED, USA**

The AED Credentialing Task Force work groups were comprised of more than 50 individuals including professional experts in the eating disorders and related fields across the globe, individuals in recovery, and family members. After at least monthly meetings from 2005-2006, each work group submitted its initial draft of recommendations relative to its topic area. These drafts were further revised at the 1 ½-day May, 2006 Stakeholders' meeting attended by work group chairs and members. An external group facilitator was hired to work with the AED Credentialing Task Force Chair to help oversee this meeting. A revised draft of each work group's recommendations was obtained by the end of the meeting. Consensus regarding recommendations was reached after extensive intra- and inter-work group discussion and presentation to the entire stakeholder group.

Further refinement and vetting of the recommendations occurred from 2007 until 2012. Various stakeholders including members of the AED, NEDA, IAEDP, program directors, insurer groups in the USA, and recovered individuals and family members reviewed and commented on the recommendations during this time. Additionally, the recommendations were posted twice for comment on the websites of the AED, NEDA and IAEDP. Survey results regarding the recommendations were also obtained twice from program directors and once from major insurers in the USA. Throughout 2004 – 2012 the AED Credentialing Task Force met monthly to maintain forward movement of the initiative and consulted specifically with ECRI Institute <https://www.ecri.org> and URAC <https://www.urac.org> to develop a work plan that would facilitate identification of an accreditation body that would use these recommendations in a formal accreditation program specifically in the USA.

The AED Credentialing Task Force developed the clinical practice recommendations for residential and inpatient eating disorder programs to: (a) safeguard patients and families who seek eating disorder residential and inpatient treatment; (b) review and improve the quality of care offered by residential and inpatient treatment programs; and (c) provide a quality of care benchmark for third party payers to consider as they collaborate with health care providers in the development of comprehensive models of care and its reimbursement. The recommendations are intended for review by eating disorder residential and inpatient treatment programs, insurers, government health officials, and accrediting organizations willing to integrate these recommendations into a program of accreditation. Additionally, these recommendations can be helpful to patients and families as they consider possible treatment program options. The following clinical practice recommendations are supported by expert clinical consensus. Those that are also supported by empirical findings are noted in the document. Work group members were asked to review the National Institute for Clinical Excellence (NICE) Guidelines for Eating Disorders (2004)¹, American Psychiatric Association Practice Guidelines for the Treatment of Eating Disorders (2006)², and Australian and New Zealand Clinical for the Treatment of Anorexia Nervosa (2005)³, as well as the American Academy of Pediatrics Policy Statement on Identifying and Treating Eating Disorders (2003)⁴ in preparation for their joint work on development of these clinical practice recommendations for residential and inpatient eating disorder programs.

WORK GROUP I RECOMMENDATIONS FOR ASSESSMENT AND TREATMENT PLANNING STANDARDS

Work group focus: Development of recommendations for credentialing guidelines for an eating disorder treatment residential facility intake and treatment planning process.

Work group co-chairs: Joel Jahraus, MD, FAED, USA; Benita Quakenbush-Roberts, PhD, USA

Work group members: Barton Blinder, MD, PhD, FAED, USA; Rich Levine, MD, FAED, USA; Janet Treasure, FRCP, UK; Luke Einerson, USA; Connie Roberts, RN, USA, Joel Yager, MD, USA.

Background and Overview Paragraph: The patient's first contact with a treatment facility is often a highly emotional and often overwhelming experience. It is essential that this initial process maximize engagement and support and minimize confusion.

Standard 1: Initial Assessment

Initial Assessment should be done promptly and effectively.

Rationale:

Stated broadly, the goal of initial assessment is to facilitate obtaining the appropriate treatment at the appropriate level of care as soon as possible. Since eating disorders are complex biopsychosocial disorders, it is essential to conduct a timely initial assessment of the individual and obtain information (as indicated) to ensure that the patient is medically stable and that the facility can provide appropriate care.

Elements of Performance:

In order to determine suitability for admission, initial assessment can be done on site or by electronic/voice communication to gather information from the patient and family (as indicated) that assists in determining the appropriateness of the individual for the facility and program. An individual knowledgeable about eating disorder symptoms and treatment may conduct the interview under the direct supervision of the manager of the facility.

Process Measures:

1. From the time of initial contact with the individual (and family as indicated) requesting admission, the initial assessment and decision-making should be accomplished within 48 hours after all necessary data has been obtained.
2. Initial assessment consists of:
 - a. An evaluation of medical stability as determined by a history and physical examination provided by a medical clinician, laboratory testing, EKG, provider consultation history, and the Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis III.
 - b. Mental health screening for DSM Axis I, II, IV, and V, substance abuse, suicidal and violence risk, history of treatment, and current treatment team including provider contact information
 - c. Nutritional screening for eating disorder behaviors, and nutritional status.
 - d. Special needs including, but not limited to, disabilities, language barriers, and communicable disease requiring isolation.

e. Assessment of impact of illness on patient and family in relation to role impairment, quality of life, and burden of care.

For children and adolescents specifically:

f. Information from the parents/guardians regarding the patient's history of present illness and the facility's ability to provide for the patient's age and developmental level.

3. The treatment facility informs applicants of the treatment that will be offered or if not, of the appropriate alternative treatment and/or facilities. In accordance with good clinical practice the facility will advise that outcomes of care are assessed by structured surveys that may include self-report, as well as clinician-completed measures. Informed financial consent is obtained from patients and family (as indicated). *In USA-based facilities patients and family (as indicated) are informed of:*

- a. *Whether the facility is considered in-network for the member's insurance company*
- b. *An estimated range of expenses for services provided*
- c. *The means and timing of payment*
- d. *The consequences of non-payment*

4. Each patient, whether voluntary or involuntary, and family (as indicated) is engaged in the process preparing them for admission:

- a. Is appropriately prepared for admission.
- b. Is assisted in understanding the reasons for admission.
- c. Is notified of all available options.
- d. Receives a pre-placement visit to the residential or inpatient treatment center, when feasible.

Outcome Measures:

Facility provides initial assessment procedures and adequate documentation demonstrating compliance with the standard. Appropriate staff may also be surveyed.

Standard 2: Admission Process

The admission should comprise a comprehensive, interdisciplinary clinical process and form the basis for individualized treatment planning and delivery.

Rationale:

A thorough assessment of an individual's biopsychosocial functioning and family system/support network ensures a more accurate understanding of predisposing, precipitating, and perpetuating factors related to the eating disorder and assesses the individual's specific medical, psychological, and nutritional needs. This allows for refinement of the diagnostic summary, and the development and coordination of a comprehensive and effective treatment plan. An interdisciplinary team of psychiatric, medical, psychological, nutritional, and/or other professionals makes admission decisions, using the organization's own assessments, medical necessity criteria, and materials from specialty organizations such as the American Psychiatric Association (APA) Guidelines for Treatment of Eating Disorders and NICE Guidelines for Eating Disorders. Timely and thorough assessment by an interdisciplinary team is also imperative given the high risk for concurrent conditions.

Elements of Performance:

Assessments are done as soon as the patient is admitted to ensure medical and psychological stability. The patient's family (including, but not limited to, family of origin, spouse, children, significant other or close friends) are included in the admission and assessment process because the patient's and family's

participation in treatment planning improves the probability of treatment compliance. Corroborating data from family members and other clinicians is collected as indicated in relation to eating disorder symptoms and severity as well as co-morbid conditions, such as substance abuse.

Process Measures:

1. Consent for treatment, contracts, releases of information, and emergency contact information as well as all other applicable program documentation are completed during the assessment. For a minor, assent from a minor and consent from the minor's parent/guardian are obtained for all treatment procedures and interventions. *In the USA, if a minor refuses to give assent but the parent/guardian gives consent, appropriate state laws are followed.*
2. The patient and, if applicable, the family are oriented to the program and its policies and procedures including expectations and rationale for family communication, clinical involvement, and visitation.
3. The facility establishes a policy for providing assessments and written evaluations provided by duly licensed and qualified health professionals within a biopsychosocial framework, in the following areas:
 - a. Medical,
 - b. Nursing,
 - c. Psychiatric,
 - d. Psychological, and
 - e. Nutritional.
4. The facility gathers information from outpatient providers and/or other treatment programs the patient has participated in within their lifetime, if available.
5. Each patient receives:
 - a. An assessment of environmental, religious, and cultural factors.
 - b. An assessment of the family when appropriate by direct involvement of pertinent family members.
 - c. An educational and/or vocational assessment, as needed.
 - d. Additional psychological testing (e.g. intelligence, personality) during the diagnostic process or later in treatment, as needed.
 - e. Substance abuse assessment.

For children and adolescents:

 - f. Developmental, educational and cognitive assessments.
6. Initial medical assessment, DSM based multi-axial diagnostic assessment, psychiatric evaluation, and nutritional assessments will be completed within 72 hours, and all assessments will be completed within one week or sooner. Psychological testing will be completed as clinically indicated. If an assessment cannot be completed within the recommended time frame, justification for delay must be documented in the medical record. The facility staff will:
 - a. Conduct an ongoing assessment of each patient and his/her family system to determine the continued necessity for residential or inpatient care or whether the patient is ready to be stepped down to a less restrictive and/or intense level of care.
 - b. Document and justify the continued need for current level of care in the case record.
8. If substance abuse is indicated by history and/or evaluation, treatment or referral will be provided.
9. The facility identifies, assesses, treats, and/or refers victims and perpetrators of abuse and neglect for treatment, in compliance with mandatory reporting laws, and for safeguarding in the case of minors at ongoing risk.
10. The patient sets goals for treatment and discharge expectations with treatment team members. The parents/guardians of child and adolescent patients participate in setting goals for treatment.

Outcome Measures:

The facility provides documentation of assessment being performed within a biopsychosocial framework, in compliance with Standard 2, #3 a-d and appropriate staff will be surveyed.

Standard 3: Treatment Planning

The clinical staff complete and regularly review a comprehensive treatment plan for each patient.

Rationale:

Comprehensive treatment and continuity of care are initiated as soon as possible to promote successful treatment.

Elements of Performance:

Treatment planning is conducted in a timely and responsive manner and provides enough information to the patient, family, and treatment team so they can proceed with the course of treatment. In order to make appropriate modifications, it is imperative to evaluate and update the individual's progress or lack of progress.

Process Measures:

1. An initial treatment plan is developed within 48 hours of admission, and a comprehensive treatment plan within 7 days to provide efficient, safe, and continuous care.
2. The treatment plan is developed with the participation of the patient, the parent/guardian (if the patient is a minor), the facility and:
 - a. Helps the patient understand the options, benefits and consequences of different treatment alternatives.
 - b. Helps the patient understand the ways the facility can support the achievement of his/her desired outcomes.
 - c. Informs each patient in advance about the benefits, risks, and alternatives to planned treatments.
3. The written treatment plan specifies a diagnosis according to criteria in the current DSM of the APA and/or ICD-10 International Classification of Diseases and the treatment plan consists of:
 - a. Patient identification on each page of the document
 - b. Description of problems
 - c. Symptoms
 - d. Patient treatment goals/expected outcomes
 - e. Expected date of goal completion
 - f. Measurable objectives to complete goals
 - g. Therapeutic interventions and responsible staff
 - h. Assets/strengths of the patient and family (as indicated) that will assist them in achieving treatment goals
 - i. Date specifying when objectives will be reviewed with patient and family (as indicated)
 - j. Signatures of patient (and parent/guardian for minors) and representatives of the treatment team
4. The facility provides procedures and documentation demonstrating Standard 3 #3 a-j.

5. The treatment team reviews (including critiques, updates and revises the plan in interactive discussion) treatment plans at least every 7 days for appropriateness, effectiveness, or when individual needs dictate.

Outcome Measures:

The facility provides the procedures listed above and adequate documentation demonstrating compliance. Appropriate staff will also be surveyed.

Standard 4: Continuity of Care

Continuity of care is provided by sharing pertinent information with appropriate individuals invested in the patient's care and well-being.

Rationale:

Continuity of care is essential to the provision of best-practice care and transition to step down services or the community after discharge. Continuity of care is accomplished through disseminating information to caregivers that then standardizes care and allows individual clinicians to work in tandem. This is particularly essential in working with patients with eating disorders who have complex cases and whose motivation for recovery may vary at different times creating the possibility for staff splitting.

Elements of Performance:

Internal continuity of care is provided by sharing applicable information promptly and disseminating it to appropriate staff. External continuity of care is ensured by providing verbal and/or written communication to step-down providers (including the patient's primary care provider and receiving mental health therapist or program) within 48 hours of a treatment determination regarding next level of care or at the time of discharge. Written consent by the patient (or parent/guardian if a minor) must be given prior to any information exchange with outside providers. *In the USA the latter is required to maintain compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) but may be overridden if required by law and the patient is at substantial risk of harm to self or others.*

Outcome Measures:

The facility provides assessment policies, procedures, and documentation demonstrating compliance.

Standard 5: Discharge Planning

The facility assists the patient in developing an after-care plan and works to assure follow-through after discharge. The facility staff provides the patient, family (as indicated) and after-care team with the appropriate information to ensure continuity of care.

Rationale:

The discharge plan should adequately inform the patient, the family, and the receiving team the level of care recommended for the patient.

Elements of Performance:

Discharge planning begins upon admission and is further developed with the patient and family/support network throughout treatment culminating in a comprehensive plan. An assessment of the prognostic features (e.g., dietary restraint, motivation for treatment, and quality of family support) and response to residential or inpatient care is conducted to determine the need for further treatment, and type of

treatment. Access to appropriate step-down care can be problematic in certain areas around the world. The treatment team will make every effort to link the patient and family with appropriate providers who are located in or near the community to which the patient is discharged.

Process Measures:

1. The discharge plan developed during the patient's treatment consists of:
 - a. Level of care recommended, based on current risk assessment.
 - b. Specific recommendations for follow-up treatment.
 - c. Medication education.
 - d. Providers names and contact information for follow-up appointments.

For children and adolescents:

 - e. Parents/guardians are involved in discharge planning, where school follow up is addressed.
2. After-care providers will be given a copy of the discharge summary upon written consent of patient within a timely manner after discharge.

Outcome Measures:

The facility follows procedures to create after-care discharge plan with the patient and family (as indicated), the discharge plan is effectively communicated to the client, and the facility can demonstrate compliance with guidelines.

WORK GROUP II

RECOMMENDATIONS FOR TREATMENT DELIVERY STANDARDS

Work group focus: Treatment delivery characteristics available for review by prospective patients, families, and relevant providers.

Work group co-chairs: Jillian Lampert, PhD, RD, MPH, FAED, USA, and Craig Johnson, PhD, FAED, USA

Work group members: Marsha Marcus, PhD, FAED USA; Phillipa Hay, DPhil, Australia; Pamela Carlton, MD, USA; Wendy Oliver-Pyatt, MD, FAED, USA; Susan Ice, MD, USA; and Bryan Gusdal, MA, Canada; Carol Cochraine, MA, LMFT, USA

Background and Overview Paragraph: Work group findings and recommendations related to treatment delivery are presented in this document. Recommended treatment delivery characteristics are described. Such characteristics should be readily available for review by prospective patients, families, and referring providers.

Standard 1: Licensure Adequately Described

In countries requiring licensure, treatment facilities should accurately state licensure on patient information materials, including websites, brochures, and information sheets about the facility, display licensure and provide details of licensure upon request. As licensure will vary widely by location and program description, there is no specific type of licensure recommended. At a minimum, a treatment facility must be licensed in the state or region in which it is located as a mental health treatment facility or program, if such licensure for the level of care is available.

Rationale:

Licensure should be adequate, legally proper, and fitting of treatment center service delivery.

Elements of Performance:

Licensure should be adequately described. Documentation of such licensure should be displayed and details of licensure made available upon request.

Process Measures:

Licensure status should be clearly stated on information available to patients, families (as indicated), and outside providers and documentation provided upon request.

Outcome Measures:

Patients and families report they received adequate information regarding facility licensure.

Standard 2: Program Accurately Described

An accurate description of program setting, components, and population served should be readily provided to consumers including prospective patients, families, and referring providers.

Rationale:

Program settings/components will vary widely by facility and population served. Consumers should be adequately informed regarding treatment techniques and modalities used at the facility. Regardless of type of treatment offered, education of treatment providers should be thorough, well-documented, and available upon request.

Elements of Performance:

Program setting/components should be adequately and accurately described in program materials. Pertinent information regarding availability of and/or transfer to alternative setting of care, if necessary, such as acute hospital, psychiatric facility, etc. should be clearly communicated to patients and families.

Population and age group served by program should be adequately described in program materials. Pertinent information regarding availability of treatment based on particular population characteristic should be clearly communicated to patients and families (e.g. only one half of available beds are open to adolescents; only females are served by program; patients must treat chemical dependency issues prior to entering program, etc.).

Program materials should contain a description of the treatment team (i.e. members of multidisciplinary team) providing services. Pertinent information regarding availability and frequency of contact should be clearly communicated to patients and families (e.g. full-time availability or available a limited number of times a week; level of medical care available when and where, etc.). Description of methods of communication (e.g. rounds, care plans, emergency calls, etc.) used among the care team should be adequately described, as well as a clear outline of established psychiatric emergency protocols.

Process Measures:

Documentation of typical pattern of transfer to alternative setting of care, description of typical population served, description of care team members, methods of communication among team, and education of team members should be available to patients, families, and outside providers upon request.

Outcome Measures:

The program's description of the services provided is adequately and accurately documented and the patients, families and referring providers indicate that they are adequately informed. In addition, the information provided is consistent with the consumer's report on whether or not the services were available at time of treatment.

Standard 3: Core Treatment Components

Treatment programs should offer all of the 4 core components of eating disorder treatment: psychological, medical/nursing, nutritional, and psychiatric care services.

Rationale:

Expert clinical consensus supports inclusion of 4 core care components of any treatment program: psychological, medical/nursing, nutritional, and psychiatric care as well as milieu therapy (i.e., day to day milieu management and support). The staff providing milieu care may vary by site and may include any multiple disciplines, such as nursing, *psychiatric technicians (in USA)*, mental health counselors, etc.

Elements of Performance:

Facilities are expected to provide care delivered by appropriately skilled, licensed professionals in each of the 4 core care areas including medical, dietetic, nursing and psychiatric. At a minimum, each patient should receive the core care components weekly, including, but not limited to, individual therapy, group therapy, family therapy (as applicable), medical monitoring, medication monitoring (as applicable), and nutritional counseling. Facilities will demonstrate that in addition to providing services based on expert clinical consensus, they also offer therapies informed by empirically-based treatments when appropriate to the individual's needs. These therapies are based on principles of cognitive-behavioral treatment (CBT) and interpersonal therapy (IPT) for adults with bulimia nervosa and family-based treatment for adolescents (<19 years of age with less than three years duration of illness) with anorexia nervosa and bulimia nervosa, as well as on principles of CBT and Supportive Clinical Management (SCM) for adults with AN.

Pertinent information regarding availability and frequency of all available particular treatment modalities should be clearly documented and communicated to patients and families, including, but not limited to, the core treatment components. A description of why particular services are offered is considered ideal (e.g. evidence-based therapies implemented, rationale for therapies offered, offerings integrate with overarching program focus, etc.). Additional information regarding specific aspects of the program should be readily available as well, such as, but not limited to, staff to patient ratio, milieu philosophy, meal supervision protocols, re-feeding protocols including whether or not tube feeding is an option, school services available, typical daily schedule, free time offered and options for free time, recreational opportunities and facilities available, policies regarding phones, privileges, passes, visitors, etc.

For children and adolescents there will specifically be:

1. Developmentally appropriate psychotherapy, psychoeducation, schooling, group therapy, active involvement of families in the treatment (as indicated), nutrition, and appropriate supervision of treatment geared to the patient's age-specific, cognitive, and developmental needs and abilities, delivered by professionals trained in the treatment of children and adolescents.
 - a. Psychotherapeutic groups are appropriate for age, developmental and cognitive level.
 - b. Education:
 - Treatment interrupts schooling as minimally as possible.
 - There is appropriate educational programming by appropriately licensed teachers.
 - Ideally, on-site schooling is available. An off-site school is acceptable for medically stable patients.
 - Special educational needs of individuals are addressed, such as learning disabilities and hearing problems.
2. Medical care provided by a professional practicing within his or her scope of practice. Physical health care by a physician who is licensed and board-certified or eligible in the field of pediatrics, adolescent medicine, internal medicine, or family practice is preferred. In some regions psychiatrists may also provide physical health care.
3. Psychiatric care provided by a professional practicing within his or her scope of practice. For patients less than 18 years of age it is recommended that the psychiatrist be a licensed, board certified or board eligible child and adolescent psychiatrist. If a child and adolescent psychiatrist is not available, then a general psychiatrist with training and experience in treating eating disorders is an acceptable alternative. *In the USA, when an advanced practice nurse (APN) is providing psychiatric care, s/he is doing so within the context of a collaborative practice agreement with a physician according to state law.*

4. Appropriate nutritional guidelines to promote growth and development in this age group. A Registered Dietician (RD) is available to provide for patients' nutritional needs. The RD will be specifically trained and experienced in eating disorders in this age group. The RD assesses, educates, and counsels patients, parents/guardians and staff on food and nutrition-related issues. A physician prescribes the diet. The RD designs, implements, and manages safe and effective nutrition-related strategies that enhance growth, development, recovery from disordered eating, address disturbances in body image, and promote lifelong health.
5. All facility staff members will have appropriate expertise in the spectrum of normal physical and psychological growth and development in this age group. They will have documented training and credentials and experience with eating disorders in this age group and work within their scope of practice.
6. A safe physical setting:
 - a. If adults are treated in the same facility, they are assigned separate sleeping quarters. If children or adolescents are housed in rooms with adults, the reason is clearly documented and follows state guidelines.
 - b. Rooms are shared with patients of the same sex and where possible, with patients of similar age and developmental level.
 - c. Minors are only permitted to leave the facility under the supervision of an appropriate adult (staff, parent, guardian, or designee of parent/guardian or staff).
 - d. Parents or guardians must give consent for visitors and for passes with visitors or peers.
 - e. The television, movies, computers, books, toys, and other equipment are appropriate for age and developmental level. Staff supervise the use of equipment, and make sure that equipment for adults only is not available to child or adolescent patients.
7. Families are involved in treatment (as indicated). If a family does not engage with the facility's efforts to involve them in treatment, staff makes ongoing attempts to explore and resolve the basis for this.

Process Measures:

Documentation of delivery of core treatment components and all other available treatment components including rationale for use, frequency, and methods of communication among team members across modality should be available to patients, families, and outside providers upon request.

Outcome Measures:

1. Patient/family reports they received/participated in the 4 core care components a minimum of one time per week. Patient/family reports they received adequate information regarding type, frequency of, and rationale for treatment modalities available through program.
2. Documentation of each core care component and the patient's and family's involvement will be in each patient chart e.g., in progress notes and treatment plans). For children and adolescents, there will be ongoing evaluation and documentation of progress in education, and developmental and cognitive appropriateness of treatment.

Standard 4: Guidelines for Nutritional Rehabilitation

Nutritional rehabilitation is a key component to successful eating disorder treatment.

Rationale:

Expert clinical consensus supports nutritional rehabilitation goals to include one or more of the following: weight restoration, weight stabilization, and symptom reduction.

Elements of Performance:

Programs are expected to provide sufficient nutritional rehabilitation to support a regular and consistent weight gain and/or measurable improvement in symptomatic eating behavior and/or urges (i.e. restricting, binge eating, purging, etc.). Such programs will provide adequate documentation of such measurable goals in their treatment plan and/or medical record.

Process Measures:

Documentation of nutritional rehabilitation guidelines and specific nutritional rehabilitation goals and/or goals pertaining to symptomatic eating behavior should be available to patients, families, and outside providers upon request (where appropriate).

Outcome Measures:

Improvement in nutritional status in line with expectations appropriate for age and developmental stage.

Standard 5: Treatment Team Providers

The core care treatment providers will be the therapist, dietitian, nurse(s), primary care physician and psychiatrist, in addition to and varied team members participating in care delivery based on program components offered.

Rationale:

Program will describe training, licensure, and continuing education credit attainment by all staff.

Elements of Performance:

Adequate and accurate description of core care team composition, frequency of delivery of care components, outline of care standards, and continuing education of staff should be readily available to prospective patients, families, and referring providers. Clear job descriptions with performance based competencies and line of supervision will be available for review.

In addition, description of training and licensure of treatment providers should be clear and readily available. Level of staff experience should be easily accessible. Staff should demonstrate completion of regular continuing education credits or similar ongoing education specific to eating disorders. Staff working with children or adolescents have documented training, credentials, and experience with eating disorders in this age group and work within their scope of practice.

Process Measures:

Adequate and accurate documentation of training, qualifications, and on-going education of treatment providers should be available to patients, families, and outside providers and prominently displayed.

Outcome Measures:

All licensed staff will annually complete discipline – specific amounts of continuing education, including at least six hours of continuing education specific to eating disorders. Programs will be able to show documentation of licensed staff annual completion of continuing education hours as well as documentation of continuing education for unlicensed staff. Continuing education may include activities

such as inservice education, local, state or national conferences, or certified on-line educational offerings.

Standard 6: Financial Issues

Financial information is of great importance to prospective patients, families, and referring providers and should be readily available. *(This information is particularly important to patients and families in the USA and other countries where private insurers reimburse health care.)*

Rationale:

Cost across programs may vary widely and may play a large part in the decision that prospective patients, families, and other interested parties (e.g. third party payers) make regarding care.

Elements of Performance:

A description of cost and insurance coverage accepted by the facility should be readily available, as well as the possibility of any sort of financial assistance available. *A USA-based facility informs the patient and family (if applicable) to the best of its ability whether or not the facility is considered in-network for the patient's insurance company.*

Process Measures:

Description of typical costs associated with a typical stay and usual program components should be available upon request.

Outcome Measures:

Adequate and accurate information regarding costs of the program and other financial matters is accessible for patients, families, and other interested parties.

Standard 7: Utilization Review and Insurance Appeals

Information regarding utilization review and insurance appeals should be readily available and adequately outlined for prospective patients and families. *This information is especially relevant for patients and families from the USA, many of whom use private insurance to pay for their health care.*

Rationale:

It is understood that patients may have external constraints on their length of stay due to life circumstance, insurance coverage, or financial issues.

Elements of Performance:

Policies regarding utilization review and insurance appeals should be discussed with patients and families (if applicable).

Process Measures:

Adequate description of utilization review and insurance appeals should be available to patients, families, and outside providers upon request.

Outcome Measures:

Patients and families (if applicable) report they received adequate information about the process of utilization review and insurance appeals.

WORK GROUP III RECOMMENDATIONS FOR QUALITY IMPROVEMENT AND OUTCOME MEASUREMENT

Work Group III-a (Quality Improvement) focus: This workgroup focused on guidelines for quality improvement measurements conducted by a program.

Work group III-a co-chairs: Pauline Powers MD, FAED, USA

Work group III-a members: Tony Jaffa, BM, BS, FRCPSych, UKUK; Christina Scribner, MS, RD, USA, Nicole Hawkins PhD, USA; Camela Balcomb, USA; Amy Hanson-Akins MSW, LISW-S, USA; Melissa Cottrell, MS APRN-CNS, USA; Jamie Vallera; Michael Berrett, PhD, USA

Work Group III-b (Outcomes Measurement) focus: This workgroup focused on outcomes measurement guidelines to describe patient progress post-discharge.

Work group III-b chair: James Mitchell, MD, FAED, USA .

Work group III-b members: Christine Hartline, MA, USA; Kitty Westin, MA, USA; Maria Rago, PhD, USA; Judith Weyl, USA

Background and overview paragraph: Treatment centers should have specified guidelines for assessing clinical performance, methods of providing feedback to the staff, and a system to determine if improvement has been made in a timely fashion. This process is often referred to as Quality Improvement (QI). The specifics of the process for measuring and reporting on clinical performance will vary at different facilities according to the type of patients treated (including their age, severity of illness) and resources of the program. There should be evidence that the program described is actually being provided and that the quality of the program elements is regularly evaluated. Measurement of patient/family satisfaction and outcome of treatment are expected to be integral parts of the quality improvement program. There should be evidence of supervision for all members of the staff both outside the facility and within the facility. It is expected that the director of the program will have had significant experience in the treatment of eating disorder patients

These standards are not meant to assess the safety and quality features of a program that are for example, *typically evaluated in state licensure within the USA* and/or certification by other organizations (*e.g., in the USA, The Joint Commission or CARF*). Rather, these standards reflect quality improvement and outcome measurement issues specifically related to eating disorders. The accreditation does not obviate the need to *consider state licensure in the USA* or accreditation by other organizations.

The types of clinical data that should be collected and reported are covered in greater detail in the Treatment Delivery section of this document. In general, the basic information to be reviewed as part of accreditation process would include:

- the length of time the facility has been open
- whether or not it is affiliated with inpatient or day treatment/partial hospitalization or outpatient services
- the number of patients accepted broken out by age and diagnosis
- ratings on the severity of illness (including duration of illness, number of previous treatment episodes, and physiological and psychological co-morbidities).

Rationale:

The goal of QI program is to ensure that appropriate care is provided to patients with eating disorders and their families so that the likelihood of recovery is maximized. In order to evaluate this goal, outcome assessment is crucial.

Elements of Performance

(See Table 2 for summary)

1. Knowledge of evidence-based guidelines for treatment of patients with eating disorders (e.g., the most recent versions of the APA Eating Disorder Treatment Guidelines and NICE recommendations). There should be evidence that the treatment staff is familiar with the latest versions of these standards and their recommendations regarding evidence-based treatment for eating disorders. The treatment center is required to provide clear rationale for their choice to provide alternative treatments.
2. Required professional qualifications for degree and licensure for all clinical personnel (as outlined in Standards 3 and 5 above).
3. Documentation of specialized training in the treatment of patients with eating disorders. This may include records of continuing education or internal training and supervision.
4. Attitude that fosters continued increase in knowledge and application of new information into the treatment protocols.
5. Documentation that the staff is continuously seeking out new information and acting on analysis of this information. This may include records of program training activities.
6. Documentation that all treatment personnel, including the director of the program, receive regularly scheduled supervision.
7. The center's QI program regularly assesses clinical performance, provides feedback to the appropriate personnel, and ensures that needed changes are made. There should be documentation of continuous self-review of both the individual practitioners and the treatment team as a whole.
8. Documentation that the program that is described is actually provided.
9. Assessment of outcomes including patient (and, if appropriate, family and other sources of support) satisfaction
10. Assessment of patient outcomes/progress at admission, during the course of the current admission, and discharge. (Though not required, certain assessments, as specified below in Table 1 should be repeated at 12-month follow-up after discharge.)
11. Documentation that information obtained from patient and family satisfaction surveys and patient outcome measurements are provided to the clinical team and, if changes are needed, these occur in a timely fashion.
12. Documentation that referring team has been contacted and that appropriate follow-up care has been arranged and utilized by the patient

Examples of Process Measurement Tools:

1. Concurrent chart audit form
2. Discharge checklist and outpatient needs assessment
3. Risk management and quality improvement measure

Outcomes Measurements Rationale:

In order to eventually demonstrate which treatments are effective, outcome measures are urgently needed. There are two portions of the required outcome measurement assessment. The first is a clinical portion (at admission a complete history and physical including height, weight, frequency of binge eating and purging, and eating disorder diagnosis; and at discharge, height, weight, frequency of binge eating and purging, and eating disorder diagnosis). If the Residential or Inpatient Treatment Center is conducting 12 month follow-ups, the treatment(s) since discharge should also be determined. The second portion of the outcomes measurement is a set of instruments. The Residential or Inpatient Treatment Center can determine which outcome measures it uses and should be able to provide the rationale for their use. However, instruments that have shown validity and reliability are strongly encouraged. There are several recommended outcome measures for assessing patients at admission, mid-treatment, at discharge, and at 12-month follow-up. For the purposes of pooling data across centers, it is recommended that, at minimum, the dataset must include:

- Eating Disorders Examination (EDE) or the Eating Disorders Examination-Questionnaire (EDE-Q)⁵⁻⁶

This measure is available for no charge. Age adjusted versions of the EDEQ are available for use with younger patients.

It is recommended that the dataset also include reliable and valid measures of the following clinical and quality of life dimensions.

Clinical Dimension

Quality of Life Scale

Mood and Depression

Functional Health and Well-Being

Eating Disorder Attitudes/Psychological Features

Recommended Measures

Eating Disorders Quality of Life Scale (EDQOL)⁷

Beck Depression Inventory II (BDI)^{*8-9}

SF-36¹⁰⁻¹¹

EDI-3¹²

*If BDI II is used findings will be promptly reviewed in order to detect changes in level of depression and maintain patient safety.

In addition, patient and family satisfaction questionnaires should be obtained at discharge. There should be evidence that the treatment team has considered these questionnaires and revised the program accordingly and in a timely fashion.

There should be evidence that the treatment team has periodically evaluated both individual and aggregate outcomes from their treatment center and that treatment has been modified appropriately.

Table 1: Outcome Measurement Assessment

| <u>Required and Recommended Outcome Measures</u> | | | |
|--|-----------|-----------|-----------|
| General | Admission | Discharge | 1 yr. F/U |
| History and Physical | + | | |
| DSM-IV-TR ED | + | + | + |
| Freq. BE/P | + | + | + |
| Ht/Weight | + | + | + |
| *Instruments | | | |
| EDE-Q | + | + | + |
| EDI-3 | + | + | + |
| BDI II | + | + | + |
| SF-36 | + | + | + |
| EDQOL | + | + | + |
| Treatment since Discharge | | | + |
| Satisfaction Questionnaire | | + | |

*Children and adolescents should be assessed using age and developmentally appropriate instruments.

Table 2: Summary of Quality Improvement Standards

1. Performance Improvement Plan with policies and procedures to ensure appropriate change and feedback. Evidence of development of QI corrective action plan and its implementation when QI monitoring reveals problem areas and needed changes. Findings regarding QI indicators are shared with leadership and program staff.
2. Program description including elements of treatment for types of patients admitted.
3. Evidence that described program is provided and that quality and effectiveness are routinely evaluated.
4. Evidence that entire treatment staff know current evidence-based treatments for eating disorders.
5. Evidence that staff continue to learn and seek out new information.
6. All staff have appropriate training in their profession and specialized training in eating disorders.
7. All staff have ongoing documented continuing education and a minimum of 6 hours per year devoted to understanding and treating eating disorders.
8. All staff, including director, demonstrate competence in their scope of practice. All staff receive clinical supervision.
9. Established program for assessing the outcome of treatment at discharge and ideally, at twelve month follow-ups.
10. Outcomes Measurement Assessment are completed at admission, at discharge, and ideally, at one year follow-up. *Programs are encouraged to include empirical assessment of patient progress during their current admission to the treatment program.*
11. There is evidence of appropriate discharge and transfer planning.

APPENDIX A

ACADEMY FOR EATING DISORDERS CREDENTIALING TASK FORCE

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APPENDIX B

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