



REDC Code of Ethics

(November 2018)

Disclaimer:

References to REDC's "Center of Excellence" and "Marketing Best Practices" documents throughout this "Code of Ethics" document are informational and for reference only. Any arguably stricter standards in the "Center of Excellence" and/or "Marketing Best Practices" documents are not enforceable under this "Code of Ethics."

Definitions:

The terms "members" and "REDC members" refer to REDC member organizations.

The terms "patient" and "patients" also extend to patients' legal guardians.

1) REDC members accurately represent their treatment outcomes.

REDC members accurately represent expected outcomes so that patients understand what they are "buying." They do not exaggerate services or promise unrealistic outcomes. They avoid superlative terms such as "cure," "full/permanent recovery," and "miraculous." Claims about clinical outcomes are based on objective criteria recommended by an outside organization, such as the American Psychiatric Association (APA) and/or the Academy for Eating Disorders (AED). Members must accurately represent measures, including providing details about sample sizes and response rates such that stakeholders can understand the degree to which reported outcomes represent a patient population. [See section 4, "Performance, Quality" in the "Center of Excellence" document. Also see the "Marketing Best Practices" document. See the Appendix of this document for additional information about clinical outcomes claims.]

2) REDC members accurately represent their range of services and the qualifications of their staff.

REDC members understand the limitations of their service offerings and never claim to treat certain conditions, including any co-occurring conditions, for which they are not qualified. All providers should have the appropriate education, training, and experience, and should limit their practice accordingly. Providers may practice up to the full scope of practice as defined by their license(s). [See section 7, "Care for Co-Occurring Disorders," and section 2, "Qualified Staff," in the "Center of Excellence" document. Also see the "Marketing Best Practices" document.]

3) REDC members offer patients clinical services that are grounded in a three-pronged approach: scientific evidence published in peer-reviewed journals; clinical expertise considered practice-based evidence; and patient values, preferences, and characteristics.

Treatment is grounded in the available research, while also focused on spurring innovations (e.g., from clinical practice, academic literature, and so forth). In addition, in keeping with The Joint Commission and CARF International standards, patient values, preferences, and characteristics are also taken into account, along with families' perspectives. Taking patient preferences into account should not be construed as allowing patient preferences to override the clinical expertise/medical judgment of treatment providers. REDC members continually review the most recent findings in eating disorders etiology, development, and treatment to ensure that treatment is up-to-date and evolving as the evidence expands. Centers maintain best practices based on new findings and treatments as the evidence bases for these grow. Through training programs and affiliations with researchers and universities, REDC members cultivate an employee base that is highly knowledgeable and trained in current industry trends, including those related to age, culture, and gender. [See section 3, "Evidence-Based Treatment," in the "Center of Excellence" document.]



4) REDC members only admit patients whose needs are appropriate for the type of treatment provided — and for the level of care provided — at their programs.

REDC members strictly adhere to guidelines from the American Psychiatric Association (APA) regarding the appropriate levels of care, and they are committed to treating at the most appropriate level of care required to meet a patient’s needs. If the program is not able to appropriately meet the clinical and medical needs of the patient, it guides the patient to more clinically and/or medically appropriate alternative treatment resources. *[See section 6, “Full Continuum of Care,” in the “Center of Excellence” document. Also see the “Marketing Best Practices” document.]*

5) In marketing their services, REDC members employ messaging that is truthful, fair, non-deceptive, capable of being substantiated, and in all respects lawful.

REDC members ensure that marketing messages communicate substantive, critical information about their therapeutic services — and are not simply an enticement to choose one facility over the competition. All express marketing claims must be substantiated or capable of substantiation with appropriate evidence when made. When eating disorders treatment programs have reasonable grounds to believe that they are offering a service that is substantially better than and/or different from others in the field, they also must be willing to have these practices studied and validated, such that the entire field can benefit. Patient testimonials must be consistent with state law, and should never be used in those states that prohibit them. Patient testimonials may not portray or imply results that are not typical for all of the member’s patients who present with similar medical conditions. It is unethical to compensate a patient for a testimonial. *[See the “Marketing Best Practices” document. See the Appendix of this document for examples of practices inconsistent with the guiding principles of REDC and the expectations of its constituent members.]*

6) REDC members do not pay or receive anything of value in exchange for patient business.

REDC members are committed to relying upon objective facts and open, honest communication — not financial enticements — as a way to engage stakeholders. REDC members do not offer financial incentives of any kind to patients, referral sources, or anyone else for the purpose of inducing (or rewarding) the referral of business.

- **No Entertainment:** REDC has a “no entertainment” policy that advises programs to structure site visits of health professionals as opportunities for education or legitimate marketing activities, not entertainment. This “no-entertainment” policy holds that where possible, education and legitimate marketing activities should occur on site. When treatment centers host a reasonable off-site educational gathering as a legitimate marketing function, they are transparent with providers and referral sources that it is a marketing activity. With regard to all of the above, a useful question to ask is: “Does this feel more like work or entertainment?” *[See the Appendix of this document for examples of practices inconsistent with the guiding principles of REDC and the expectations of its constituent members.]*
- **Travel:** Reimbursement for travel, accommodations, and meals must be “reasonable.”
- **Gifts:** The giving of substantial gifts to patients and potential patients, referral sources and potential referral sources, and other types of stakeholders is strongly discouraged. Items of only nominal value — generally defined as \$25 or less — are acceptable, with a preference for items that have a purpose or intent related to education and assisting treatment, such as a book or workbook. Under no circumstances shall a gift of cash or cash equivalents (i.e., gift certificates) be given. Care should be exercised to ensure that any gift cannot be reasonably construed by the recipient as a bribe or improper inducement.



- **Referrals:** In general, payments of anything of value to referral sources, either explicit or implicit, direct or indirect, in an effort to induce (or reward) a referral of business that is reimbursable by a government payer or, in many states, a commercial payer, are illegal and are not acceptable unless there is a “safe harbor” that applies which permits the payment.

One of the safe harbors protects payments by employers to employees who receive a W-2 to reward the employee’s efforts to help the employer build a practice, e.g., production bonuses or compensation based on percentages of collections generated by the employed provider. In contrast, production bonuses and percentage collections paid to consultants who receive a 1099 instead of a W-2 may be illegal if one purpose of the payment is to induce the referral source to generate business. This area is very nuanced and fact-specific and members should work with their legal counsel to understand which arrangements are permissible and which are not. In all cases, however, referral sources (whether employed or not) should not be incented to admit patients or to extend patients’ lengths of stay when patients do not need treatment.

- **Transportation Subsidies:** At times, treatment centers encounter patients with financial constraints that include an inability to pay for transport to the treatment facility. Transportation scholarships and subsidies should be used sparingly, and only in cases where there is a genuine, demonstrable financial need. Transportation subsidies should never be used as enticements for patients to choose one program over another.
- **Documentation:** All funds expended for education and legitimate marketing activities for business purposes and gifts must be accurately documented and reflected in the books and records of the treatment center.

[See the “Marketing Best Practices” document. Also see section 5, “Sound and Ethical Business Practices,” in the “Center of Excellence” document.]

7) Prior to admitting a patient, REDC members clearly communicate the cost of treatment that may be required in both the short term and the long term.

Treatment programs in our industry often must admit patients without full information about what payers will and will not cover. This lack of transparency in health-insurance reimbursement makes it difficult to predict the out-of-pocket burden on patients and their families. Despite this challenge, REDC members should do everything in their power to ensure that patients and families are as well-informed as possible about the cost of services and patients’ and families’ financial responsibility for those services, such that patients and families can make informed decisions about how that financial obligation is likely to affect them in both the short term and the long term. Prior to admitting patients, REDC members have honest conversations with patients and families about recidivism rates and the typical illness duration and course of care that may be required over a patient’s lifetime. REDC members accurately communicate regarding their prices, expectations about patient out-of-pocket costs, and how long a patient is expected to require treatment. REDC members do not overstate the likelihood of insurance coverage or their ability to negotiate single-case agreements with insurance companies — or minimize expectations about the patient’s financial obligations. REDC members are explicit with patients and families about whether treatment programs are in-network or out-of-network with various insurance companies. When a treatment facility is out-of-network with an insurance company, it does not use misleading language such as that the program “participates with” that insurer. In short, patients must be clearly informed of their financial responsibility. *[See section 5, “Sound and Ethical Business Practices,” in the “Center of Excellence” document.]*



8) REDC members disclose financial relationships and any potential conflicts of interest that might affect patient care.

REDC members alert patients about any internal or external relationships, financial or otherwise, that their programs have that might affect patient care. If a REDC member directs a patient from one program to another in which the member has a financial interest, patients should be informed of that fact. It is unethical for programs not to disclose to patients any relationships and/or financial incentive arrangements that might affect patient care. *[See section 5, "Sound and Ethical Business Practices," in the "Center of Excellence" document. Also see the "Marketing Best Practices" document.]*

9) When participating in media interviews, REDC members are focused on educating the public and raising awareness about eating disorders.

REDC members embrace opportunities to participate in responsible and authoritative interviews aimed at educating audiences and raising awareness about eating disorders. Treatment programs have a solemn responsibility to be good citizens in all forms of media in which they participate. *[See section 11, "Advocacy," in the "Center of Excellence" document. Also see the "Marketing Best Practices" document.]*



Appendix

The following are examples of practices inconsistent with the guiding principles of REDC and the expectations of its constituent members. These are examples only, to offer clarification of intent to REDC members and interpretative guidance to persons entrusted with the adjudication of ethical practices. These examples are not intended to constitute a comprehensive list. Other practices not expressly listed here may also be inconsistent with the guiding principles of REDC.

Code Item No. 1 — Clinical Outcomes

When making claims about outcomes, it is acceptable for programs to note that they take patient satisfaction surveys into account. The patient experience is important and surveys about patient satisfaction provide useful data points. However, statements about outcomes should not be solely based on patient satisfaction. Claims about clinical outcomes should be based on objective criteria recommended by an outside organization, such as the American Psychiatric Association (APA) and/or the Academy for Eating Disorders (AED).

Code Item No. 5 — Marketing Messages

REDC members do not make hyperbolic claims designed to entice patients away from competitors with false promises and/or baseless comparative statements, such as “We take all other programs’ failures.” REDC members also avoid misrepresenting the range of services offered by other programs and/or the qualifications of other programs’ staffs.

Code Item No. 6 — No Entertainment

Lavish dinners and activities such as harbor cruises, helicopter rides, and golf outings are examples of practices inconsistent with the guiding principles of REDC and the expectations of its constituent members.



Code of Ethics Pledge & Release of REDC

[Note: This form should be signed by an officer at each REDC member organization. Each officer is signing on behalf of his/her organization.]

Pledge

I understand that eating disorders are complex and sometimes lethal illnesses. An American dies roughly every hour as a direct result of one. I believe that those who treat these illnesses must pledge themselves to nothing short of the highest standards of conduct in both their clinical approach and their business practices.

Therefore I, _____, an officer of (fill in REDC member organization) _____, pledge to uphold the behaviors outlined in the REDC Code of Ethics.

Release of REDC

REDC member organizations acknowledge that they and their representatives may become involved in an investigation under REDC's Grievance Process alleging a violation of the REDC Code of Ethics. Continued membership in REDC after adoption of this Grievance Process and the Code of Ethics constitutes acceptance and ratification of the following release:

I, _____, on behalf of (fill in REDC member organization) _____ and its representatives, hereby forever release and covenant not to sue REDC, members of the REDC Ethics Committee and members of the REDC Board of Directors ("Releasees") from any and all claims, known or unknown, that they or any of them may have against Releasees or any of them in connection with any investigation or proceeding under REDC's Grievance Process.

Date: _____

Signature: _____

Printed Name: _____

Title: _____

Employer: _____

Business Email Address: _____

Business Phone Number: _____