Eating Disorders from a Behavioral Health Lens:

Identifying Eating Disorders and Referral Process

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When your child needs a hospital, everything matters.℠

Learning Objectives

1. Recognize common red flags, risk factors, and co-occurring conditions that may signal an eating disorder in a primary care setting.
2. Utilize validated screening tools and apply effective patient-centered questions to assess for disordered eating behaviors.
3. Differentiate levels of eating disorder care and formulate appropriate referral pathways to behavioral health and multidisciplinary teams.

Diagnosis and Prevalence

Types of Eating Disorders

Anorexia Nervosa (AN)
- Inability to consume adequate nutrition, leading to low body weight or failure to meet growth trajectories
- Intense fear of food and weight gain
- Disturbance in body perception
- May include binge eating and purging

Bulimia Nervosa (BN)
- Binge eating, followed by purging (vomiting, laxatives, diuretics) or a non-purging compensatory behavior
- Self-evaluation is unduly influenced by body weight and shape
- Often “normal” weight

Binge Eating Disorder (BED)
- Binge eating accompanied by marked distress
- Absence of ‘compensatory’ behaviors
- Can be any weight; weight gain often occurs as eating disorder progresses

Avoidant/Restrictive Food Intake Disorder (ARFID)
- Failure to meet nutritional/energy needs due to eating or feeding disturbance
- Associated with weight loss, nutritional deficiency, or failure to meet growth trajectories

Other Specified Feeding or Eating Disorder (OSFED)
- Purging Disorder
- Atypical AN/BN
- BN/BED of Low duration/Frequency

Unspecified Feeding or Eating Disorder (UFED)
- Symptoms of feeding and eating disorder are present but do not meet full criteria for diagnosis
- Insufficient information for diagnosis

A lot of the ideas and beliefs people with eating disorders have are strongly supported by societal/environmental norms.

Managing response to social norms is critical to recovery.

People do not "get" an eating disorder to "control something in their life."

People with eating disorders may have a history of trauma that contributes to etiology, but this is not true for all cases.

Traits and temperament – and their neurobiological underpinnings – can be embraced and directed to help in recovery.

A lot of the ideas and beliefs that people hold about weight and size are strongly supported by societal/environmental norms.

Research shows large numbers of patients with eating disorders experience weight stigmatizing responses from healthcare professionals.

Weight is not fully controllable by “will power” and is influenced heavily by genetics.

BMI is a faulty mechanism for determining health and should not be used for individual evaluations of optimal body size.

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Nine More **Truths** about Eating Disorders: Weight and Weight Stigma

1. Weight is influenced by multiple factors, including biological, psychological, behavioral, social, and economic factors.
2. There is a complex relationship between weight and health that is different for each person. Body mass index is an imprecise proxy measure of adiposity and is not a direct measure of health.
3. Weight is sensitive and personal, as it is determined and experienced uniquely for each individual and, when appropriate to do so, should be approached thoughtfully and respectfully. At the same time, weight is a highly politicized issue with social and economic linkages that intersect with social inequalities.
4. Weight bias and weight-based discrimination are prevalent and have pervasive negative consequences for health, social relationships, education, employment, and income. Weight bias is one facet of the cultural appearance ideals that emphasize and idealize thinness and are implicated in the development and maintenance of disordered eating behavior.
5. All people, irrespective of their weight, deserve equitable treatment — in healthcare settings and society. Weight bias and weight-based discrimination are never acceptable.
6. Weight is assessed by objective physical measurement; whereas, the threshold of body mass index used to classify obesity is based on arbitrary medical convention. Eating disorders are defined by thoughts, feelings and behaviors, and obesity is not an eating disorder.
7. Accurate judgments about a person’s cognitions, personality, or behaviors cannot be made on the basis of their weight and appearance, and eating disorders cannot be diagnosed on the basis of a person’s weight or appearance. Eating disorders affect people across the weight spectrum.
8. Dietary restriction can increase the risk for developing an eating disorder and can be harmful for many individuals across the weight spectrum. This risk must be considered during discussions and interventions relating to diet and weight.
9. Positive body image, regardless of weight, protects against disordered eating and other mental health problems and is associated with better physical health outcomes.

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Co-occurring Diagnoses

- Anywhere from 48-81% of people, depending on the diagnosis, who have an ED show signs of an anxiety disorder *before the onset of their ED* and that *likely persist after someone is in recovery.*
- Roughly 1 in 6 people with an ED also have OCD.
- Approximately 50% of people with eating disorders also have depression.
- About 25% of people also have PTSD.
- Up to 50% also have a substance use disorder.
- Not only do these illnesses pose a greater risk of death due to medical complications of an eating disorder, but they present an increased risk of death by suicide as well. Between 25-33% of people with anorexia and bulimia have attempted suicide, and someone with anorexia is 18 times more likely to die by suicide than those without an eating disorder.

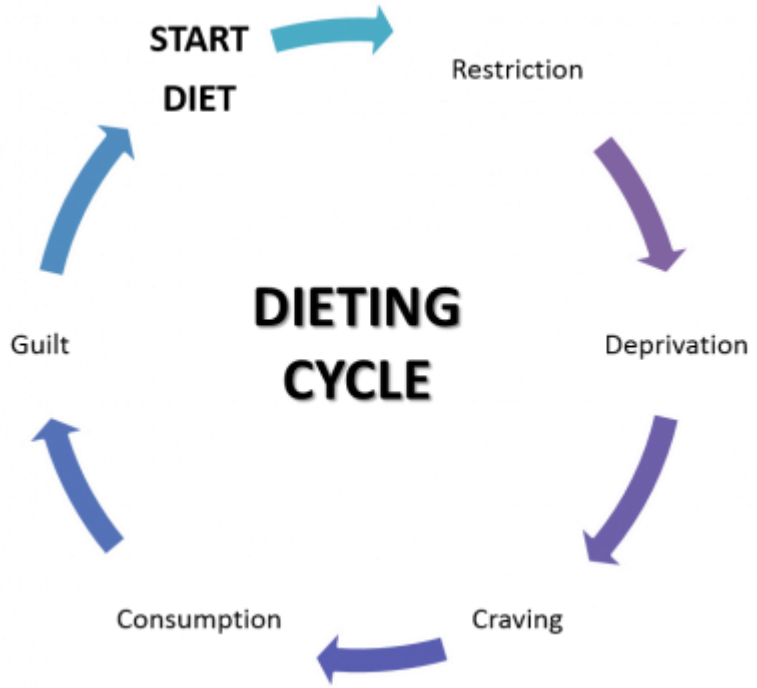
From Dieting to Disorders

Diets vs EDs

- Many people diet/restrict/limit eating/overeat
- Many people have environmental and experience/psychological risk factors?
- BUT not all these folks develop an ED – in fact, more people develop disordered eating that can become an eating disorder, remain sub-clinical or extinguishes itself.
- Why is this the case?

Disordered Eating or an Eating Disorder?

- Is there a **pattern** of behaviors?
- Is there **preoccupation**?
- Is there **impairment**?



Signs & Symptoms

What Might I See?

Growth

- Excessive or rapid weight gain or loss
- Failure to achieve or maintain appropriate increases in weight or height
- Notable fluctuations in weight

Cardiovascular, Bradycardia or Arrhythmia

- Chest pain
- Palpitations
- Orthostatic tachycardia or hypotension
- Shortness of breath
- Edema in the extremities
- Cardiac murmur

Gastrointestinal/Abdominal

- Bloating
- Early satiety
- Reflux
- Vomiting or hematemesis
- Constipation
- Hemorrhoids or rectal prolapse

Skin/Hair

- Brittle and breaking hair and nails
- Thinning hair or nails, or hair loss,
- Dry, sallow skin
- Lanugo
- Carotenemia or carotenoderma (appearing orange),
- Calloused knuckles
- Poor wound healing
- Bruising on the spine from excessive exercise

What Might I See, continued

Neurological

- Orthostatic changes/dizziness
- Weakness
- Memory loss
- Seizures/epilepsy

Endocrine

- Cold extremities or cold intolerance
- Hot flashes or sweating episodes
- Stress fractures or low bone mineral density
- Primary or secondary amenorrhea or oligomenorrhea

Psychological

- Excessive concern about weight or body image
- Inappropriate dieting, including rigidity about types or quality of foods
- Compulsive exercising
- Fatigue
- Insomnia
- Self-injurious behavior or suicidality
- Depression
- Anxiety disorders
- Obsessive Compulsive Disorder
- ADHD

Eating Disorders Signs for Providers

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	Eating Disorder	Physical Symptoms	Medical Examination
Anorexia Nervosa	• Extreme food restriction, intense fear of weight gain, distorted body image • Leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. • **Subtypes:** Restricting type & Binge-Purge type • Can lead to life-threatening complications due to malnutrition	• Anemia, leukopenia, thrombocytopenia • Bone mineral loss, osteoporosis osteopenia • Muscle loss • CV problems: Bradycardia, hypotension, CHF • Brain and nerve problems: Decreased focus, slow thinking • GI: Constipation, gastroparesis, bloating, reflux, Elevated liver enzymes or kidney problems • Endocrine system issues like Low T3 syndrome • Amenorrhea or irregular periods in females • Decreased testosterone in males • Dermatological changes: Dry skin, lanugo hair • Electrolyte abnormalities: Low P, Mag, K, Na • Anxiety, depression	• For patients with restrictive eating behaviors: (AN, AAN, ARFID, AN-B/P) - Weight history, including the growth chart review - Vital signs including orthostatic vitals and temperature - Blood work including CMP, CBC, Mag and Phos - Hormonal evaluation (for patients with delayed puberty or amenorrhea) that includes LMP or estradiol/free testosterone levels - Consider Dual-energy X-Ray Absorptiometry (DEXA) - Physical exam with attention to medical complications of starvation (eg Bitemporal wasting, cool extremities)
Bulimia Nervosa	• Recurrent binge eating (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances) • Followed by compensatory behaviors (vomiting, laxatives, excessive exercise) • Usually maintains a normal or above-average weight • A sense of lack of control overeating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating) • Risk of severe electrolyte imbalances and heart complications	• Preoccupation with food and weight low self esteem anxiety and depression • Erosion of dental enamel swollen jaw, bad breath, gum disease, tooth decay • Chronic sore throat, indigestion, heartburn, reflux, inflamed or rupture of esophagus • Irregular heart rate or bradycardia, cardiac arrest, heart failure, low blood pressure, fainting, dizziness • Stomach ulcers, pain, stomach rupture • Bowel problems, constipation, diarrhea, cramps • Irregular or absent periods loss of libido and infertility • Dehydration of kidneys • Calluses on the knuckles, dry skin, and muscle fatigue cramps caused by electrolyte imbalance, tiredness and lethargy	• For patients with Binge eating behaviors: (BED, BN, AN-B/P): - Weight history, including the growth chart review - Orthostatic vital signs - Blood work including CMP, HbA1c, Lipid panel - Hormonal evaluation (LMP) - Physical exam with attention to medical complications associated with weight gain (Jaundice, airway patency)
Binge Eating Disorder	• Frequent binge episodes without compulsory behaviors • Associated with obesity, diabetes, and cardiovascular disease • Often linked to emotional distress and guilt • Recurrent episodes of binge eating • Eating more rapidly than usual • Eating until feeling uncomfortably full • Eating large amounts of food when not feeling physically hungry • Eating alone because of feeling embarrassed by how much one is eating • Feeling disgusted with oneself, depressed, or very guilty afterward • Marked distress about the binge-eating episodes	• Weight gain, fatigue, lethargy • Low self esteem, anxiety, depression, guilt, distressed by behavior • Sleep Apnea • High blood pressure, high cholesterol, stroke, heart attack • Gallbladder disease • Type 2 diabetes • Chronic kidney problems, kidney failure • Osteoarthritis	• Weight history, including the growth chart review - Orthostatic vital signs - Blood work including CMP, HbA1c, Lipid panel - Hormonal evaluation (LMP) • Lipoprotien panel (Cholesterol & Triglycerides) • Liver function tests (LFTS) • Fasting Blood Glucose & HbA1c • Thyroid Function Tests (TSH, T3, T4) • Liver Function Tests (ALT, AST, GGT) • Kidney Function Tests (Creatinine, BUN, eGFR) • Cortisol Levels (Dexamethasone Suppression Test) • Insulin & C-Peptide Levels • Leptin & Ghrelin Levels

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	Eating Disorder	Physical Symptoms	Medical Examination
ARFID	• Extreme selective eating due to sensory issues, fear of choking, or lack of interest in food • Not driven by body image concerns • Can result in growth delays and nutritional deficiencies	• Significant weight loss (or failure to gain weight in children) • Extreme thinness or underweight (in severe cases) • Fatigue and low energy levels • Pale or dry skin • Hair thinning or hair loss • Brittle nails • Dizziness or fainting • Chronic bloating or stomach pain • Constipation (due to low fiber intake) • Nausea after eating • Early fullness (feeling full after eating very little) • Acid reflux or heartburn • Delayed growth or puberty • Failure to meet height and weight milestones • Weakened immune system (frequent illnesses) • Strong aversions to certain food textures, colors, or smells • Gagging or choking when trying new foods • Extreme pickiness with very limited food variety	• Weight history, including the growth chart review - Orthostatic vital signs - Blood work including CMP, HbA1c, Lipid panel - Hormonal evaluation (LMP), Complete Blood Count (CBC), CMP • Vitamin deficiencies such as Scurvy by doing blood work for such levels and also targeted physical exam for signs like bleeding gums, angular cheilitis, geographical tongue, etc. • Serum Iron • Ferritin • Total Iron Binding Capacity (TIBC) & Transferrin Saturation • Vitamin B12 & Folate Levels • Thyroid-Stimulating Hormone (TSH), Free T3 &T4 • Vitamin D, Ca, Mg , P, Zn, Cu • IGF-1 & IGFBP-3 • GH Stimulation Test • DEXA Scan • Prealbumin & Albumin
OSFED	• Atypical presentations of eating disorders that don't meet full diagnostic criteria • Includes **atypical anorexia, purging disorder, and night eating syndrome**	• Unexplained weight loss or weight fluctuations • Extreme fatigue and low energy levels • Dizziness or fainting (due to dehydration or low blood pressure) • Cold intolerance (feeling cold all the time, especially in extremities) • Dry or pale skin • Hair thinning or hair loss • Brittle nails • Psychiatric comorbidity: Anxiety depression, OCD • Use of psychotropic medications, self-harm, suicidal ideation	• For patients with restrictive eating behaviors: (AN, AAN, ARFID, AN-B/P) - Weight history, including the growth chart review - Vital signs- including orthostatic vitals and temperature - Blood work including CMP, CBC, - Hormonal evaluation (for patients with delayed puberty or amenorrhea) that includes LMP or estradiol/free testosterone levels - Consider Dual- energy X-Ray Absorptiometry (DEXA) - Physical exam with attention to medical complications of starvation (eg Bitemporal wasting , cool extremities) • For patients with Binge eating behaviors: (BED, BN, AN-B/P): - Weight history, including the growth chart review - orthostatic vital signs - Blood work including CMP, HbA1c, Lipid panel - Hormonal evaluation (LMP) - Physical exam with attention to medical complications associated with weight gain (Jaundice, airway patency)

Medical Consequences of Eating Disorders

- Cardiovascular Issues – Irregular heartbeat, low blood pressure, risk of heart failure
- Gastrointestinal Problems – Constipation, bloating, acid reflux, delayed gastric emptying
- Endocrine Disruptions – Loss of menstrual cycle (amenorrhea), osteoporosis, thyroid dysfunction
- Neurological Effects – Cognitive impairment, dizziness, fainting, seizures
- Electrolyte Imbalances – Low potassium (hypokalemia), sodium, and magnesium levels
- Dental Damage – Tooth erosion and gum disease due to purging behaviors

Treatment Approaches

- Medical Stabilization – Addressing malnutrition, dehydration, and heart risks
- Nutritional Rehabilitation – Working with dietitians for structured meal plans
- Psychotherapy – Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Family-Based Therapy (FBT)
- Medication – Antidepressants or appetite regulators when needed
- Inpatient, Residential, or Outpatient Care – Based on severity

Key Takeaways

- Eating disorders affect both mental and physical health and require multidisciplinary treatment.
- Early intervention improves outcomes, and treatment often involves medical, nutritional, and psychological care.
- Left untreated, eating disorders can be life-threatening, with one of the highest mortality rates among psychiatric disorders

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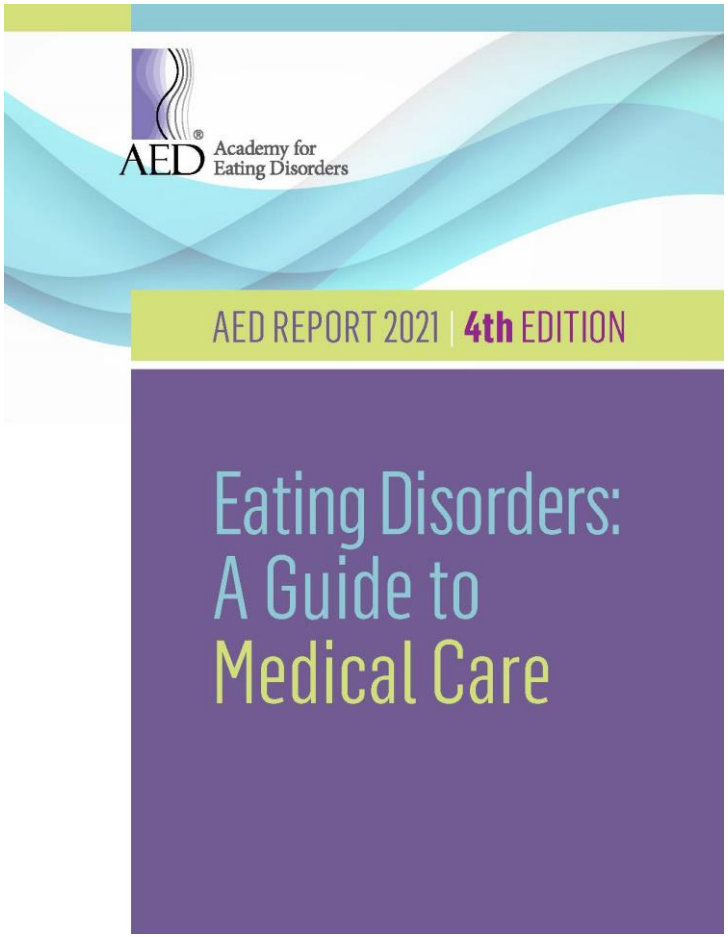
Personality Trait Considerations

Anorexia Nervosa

- Harm avoidance
- Risk averse
- Persistent
- High noticing
- Obsessional
- Anxious
- Reward dependent
- Perfectionistic
- Low novelty seeking
- Fearful

Bulimia Nervosa and Binge Eating Disorder

- Negative urgency
- High reward response
- Novelty Seeking
- Quick-tempered
- Excitable
- Exploratory
- Not risk averse
- Impulsive
- Easily bored
- Easily form emotional attachments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AED REPORT 2021 | 4th EDITION
Eating Disorders:
A Guide to
Medical Care

Screening Considerations

Key Principles

Malnutrition can occur in patients of any weight

- Any concern expressed by a parent or caregiver about a child's eating behaviors, weight, or shape should heighten concern for a possible eating disorder (current or future), ***regardless of their weight or BMI.***

Screen consistently and early

- Early recognition can provide the opportunity to intervene before more severe consequences occur.
  - The **American Academy of Pediatrics (AAP)** – PCPS should screen for Eds during annual exams/sports physicals; ask surveillance questions about eating patterns and body image to all preteens and adolescents.
  - The **American Academy of Child and Adolescent Psychiatry** - mental health providers should screen all child and adolescent patients for eating disorders.
  - The **American Psychiatric Association and the American Psychological Association** - providers screen all adult clients for eating disorders.

Lethality Considerations

Consider more frequent screening and vigilance when an eating disorder is suspected or diagnosed.

Why?

While routine screening for depression and suicidality is recommended at all preventive care visits for youth ages 12-18, suicide rates are increased in patients with eating disorders.

6x **The mortality** rate for persons with eating disorders is up to 6 times that of their peers.

31x **The suicide rate** has been calculated as high as 31 times that of their peers.

34 **The average age of death** due to an eating disorder is 34 years old.

52 **Every 52 minutes, an American dies** as a result of her or his eating disorder.

Presenting for Treatment

- Patients may be **uncomfortable disclosing information** about their behaviors; often deny or minimize their symptoms – however, this isn't "lying."
  - objective measures such as weight and physical markers assist with validating if an eating disorder is present
  - Use of self-report screening tools are important and valuable

- **Caregivers/support persons should be included** in the assessment process wherever possible.

- A **thorough medical examination** by the person's PCP is best practice.

- Patients may not present for ED treatment but be seeking support for **other, often related, physical & psychological signs and symptoms.**

- Cooccurring psychiatric illnesses are seen in up **to 80% of patients** with an eating disorder and therefore should be examined in addition to the physical manifestations of the disorder.

Ask.

Approximately 50% of adolescents who met full criteria for one of the EDs never talked about their concerns despite having contact with a health care provider.

This suggests that prevention and early intervention is critical.

Source: Swanson SA, Crow SJ, Le Grange D, Swendsen J, Merikangas KR. Prevalence and correlates of eating disorders in adolescents. Results from the national comorbidity survey replication adolescent supplement. Arch Gen Psychiatry. 2011 Jul;68(7):714-23.

Screening

- SCOFF
  - High sensitivity and specificity, especially in AN and BN
- Eating Disorder Screen for Primary Care (ESP)
  - Five yes/no questions
- Adolescent Binge Eating Disorder Screener
  - Ado-BED
- Eating Disorder Examination Questionnaire

Assessment Overview

Positive Screen - Now What?

- Time to dig deeper.
- Use a mixture of closed-ended question and open-ended ones. Standardized assessments are also an option.
- Remain curious and listen for places where an answer could be vague.
  - "Eating disorders live in the gaps"
- Due to the bio-psycho-social nature, a comprehensive assessment is critical for assessing appropriate intervention, so the therapist interview is just one piece of the puzzle.
  - A physician with training and experience with eating disorders will check CBC, CMP, and electrocardiogram (ECG) for all clients and selectively use the following tests: leptin level, TSH and T4, amylase and lipase, gonadotropins (LH, FSH) and sex steroids (estradiol, testosterone), Dual Energy X-ray Absorptiometry (DEXA)
  - A symptom-based referrals to a pediatric cardiologist, endocrinologist, psychiatrist, behavioral health specialist, and/or pediatric gynecologist may be needed.
  - A refer to a multi-disciplinary treatment program that includes therapy, dietetic support, medical oversight, and psychiatric support.

Sample Interview Question Bank

- How much of the day do you think about your weight and body shape?
- What makes you avoid the foods you do, outside of food allergies or religious reasons?
- Do you go on diets? If so, how often? When was your last diet?
- How important is your weight/shape/size to your sense of self/identity?
- Are you fearful of gaining weight?
- Do you often feel out of control when you eat?
- Do you ever eat what others may consider to be a large quantity of food at one time? If so, how often?
- Do you regularly eat until feeling uncomfortably full?
- Do you hide what you eat from others or eat in secret?
- How do you feel after eating?
- Do you ever make yourself vomit (throw up) after eating?
- Do you use your insulin in ways not prescribed to manage your weight?
- Do you take any meds or supplements to compensate for eating or to give yourself permission to eat?
- What are your motivations for exercise and physical activity?
- Do you enjoy the physical activity you do?
- How do you feel about yourself when you miss a day of exercise/activity?
- Have people expressed concern about your relationship with food or your body?

A Unique Piece of ED Assessment: the 24-hour food recall

- This assesses overall food and fluid consumption for a 24-hour continuous period.
- Listening for details and specifics is crucial here.
- Suggested phrasing
  - "So, it's 10 AM now. Can you tell me everything you've had to eat and drink in the last 24 hours? I'm interested to hear amounts and times."
  - "Do you feel like this is a pretty typical day for you?"
    - If not, "What made the past 24 hours different?"
- NOTE: The same questions can be posed regarding movement if you suspect the client is excessively exercising.

Remember -

- The #1 medicine for treatment is appropriate nutrition and that needs to occur **simultaneously** with therapy

- You **can't talk someone out** of poor body image
  - Research demonstrates cognitive impairment caused by poor metabolic functioning

- **Do not wait; do not pass go**: "Waiting" for it to pass or viewing it as attention seeking behavior could cause irreversible damage

Eating Disorder Levels of Care

1	**Inpatient:** For patients in significant physical danger and/or who are medically unstable; these patients cannot be treated safely without the availability of immediate medical intervention. Typically hospital-based. **Necessary in cases of medical and/or psychiatric instability or complications, typically 2-5% of treated individuals.**
2	**Residential:** 24-hour care/supervision for medically stable patients who are engaging in ED behaviors (i.e. self-induced vomiting, restrictive eating, or compulsive exercise); daily behavioral focused interventions, individual and group therapy, and family support are provided. May be in free standing facility or hospital facility. **Typically needed by approximately 5-10% of treated individuals.**
3	**Partial Hospitalization (PHP):** Comprehensive care; typically 5-7 days per week for 6-10 hours per day; usually includes two or more therapeutic meals, daily behavioral interventions, individual and group therapy, and family support. **Typically needed by approximately 10% -15% of treated individuals.**
4	**Intensive Outpatient (IOP):** Less comprehensive care; typically 3-4 times a week for 3 hours per day; provides one therapeutic meal, daily behavioral interventions, group therapy and family support. Patients can continue working or attending school while in treatment. **Typically needed by approximately 15-20% of treated individuals.**
5	**Outpatient:** Treatment is delivered in office setting, may include individual therapy, nutrition and medical interventions; may include group and or family therapy, for adolescents typically includes family as primary means of support and intervention. **Typically appropriate for approximately 60-70% of treated individuals.**

Who's Who on the Team

THERAPIST

- Assesses/treats symptoms of related diagnoses (anxiety, depression)
- Monitor and address suicidal thoughts/self-injury
- Psychoeducation on relationship between ED, self-concept, correlation with other Dx, neurobiology
- Explore etiology and maintaining factors of ED
- Body image
- Teach coping skills

PSYCHIATRIC PROVIDER

- Prescribing of pharmacological interventions
- Assessing and diagnosing EDs and other mental illnesses
- Medication monitoring
- Education regarding psychological implications of ED

DIETITIAN

- Meal Planning
- Nutrition education
- Establishment of weight range
- Education regarding physical aspects of ED
- Weight monitoring
- Strategizing food related activities
- Body image
- Teach coping skills

MEDICAL PROVIDER

- Medical monitoring and treatment of medical conditions related to ED
- Medication monitoring
- Weight monitoring
- Education regarding physical aspects of ED

Our Goals

In treatment, we are trying to help individuals:

- Interrupt the behaviors that are causing damage to their body.
- Practice mindful movement that brings joy and positive connection with one's body
- Eat sufficiently and consistently throughout the day for adequate nourishment
- Choose a variety of foods based on preference and not fear
- Learn to wade through nutritional sensationalism to stay on one's own healthy path
- Experience eating before, during, and after with minimal anxiety, guilt, and/or shame
- Focus on health
- Appreciate the body for its resilience and wonder, not just its aesthetic
- Think critically about media messages about weight, shape, and food
- Employ adaptive coping skills

Intuitive Eating

1. Reject the Diet Mentality
2. Honor Your Hunger
3. Make Peace with Food
4. Challenge the Food Police
5. Discover the Satisfaction Factor
6. Feel Your Fullness
7. Cope with Your Emotions with Kindness
8. Respect Your Body
9. Movement – Feel the Difference
10. Honor Your Health – Gentle Nutrition

But they won’t take the recommendation…

How to Motivate the Unmotivated Client

- Motivating a resistant client is hard.
- Using Motivational Interviewing can be valuable to help a client consider any parts of their illness from which they may want relief.
  - *Humor me – can we make a pros and cons list about getting treatment? Let's be as thorough as we can on both sides.*
- Someone doesn't have to be totally bought in to recovery to begin treatment.
  - *Is there anything about your life with this illness that's feeling hard to manage? If so, what might it be like to talk to someone about that part?*
- A person can be ready for change in one part of their illness while uncertain or outright opposed to change in another.
  - *It sounds like you are really invested in not eating too much, but you hate purging. Tell me what it might be like to have relief from the purging.*
- There are always reasons why not to get care; your opportunity is to help them explore all the reasons TO seek care.
  - *You've done a good job of listing all the cons about getting treatment. Is there any pro, even if it's small, to GETTING care?*
- Involving loved ones can help massage a client's willingness to get the care they need.
  - *What would your best friend say if they knew this treatment was being recommended?*
- Recognize that referring to a higher level of care may be life or death for a client.
  - *I feel worried when I hear about your symptoms. I know these illnesses can be deadly. Do you ever think about that?*
- If a person is not ready now, that does not mean they will never be ready.
  - *What would you think about us making an appointment again for two weeks from now and revisiting how this conversation landed with you?*
  - *Is there anyone in your life that you'd like to have join us?*

Referral Options for Eating Disorders

Nationwide Children's Hospital

- Multidisciplinary Team
  - Therapy
  - Nutrition
  - Psychiatry
  - Medical – Adolescent Medicine (M-DEED)

Currently providing Outpatient Level of Care

Patients 8-21y

Transdiagnostic Treatment Models

*To refer for Clinical Nutrition services, a medical referral is required

Eating Disorder Referral

- Place Behavioral Health Referral (online or through Epic)
- Triage telephone call with our Resource Coordinator
- Placed on Waitlist for Therapy and Clinical Nutrition
- Behavioral Health Therapist will refer for Adolescent Medicine and Psychiatry if necessary
- Assessment will help determine if a Higher Level of Care (HLOC) for Eating Disorders is recommended

The Emily Program Columbus

Levels of Care (available in Columbus & Cleveland) - adolescents & adults

- **Residential:**
  24-hour behavioral and medical supervision in a supportive, home-like setting.
- **Partial Hospitalization / Intensive Day Program (PHP/IDP):**
  6 hours/day, 5–6 days per week; structured programming with medical, nutritional, and therapy support.
  In-person and virtual options available.
- **Intensive Outpatient Program (IOP):**
  3 hours/day, 4+ days per week; step-down or entry-level support.
  Flexible scheduling options for college students and working adults.
- **Outpatient:**
  Individual, group, and family therapy with ongoing nutrition and medical monitoring.

Treatment Highlights

- Multidisciplinary team: therapists, dietitians, physicians, psychiatrists
- Therapeutic meals and meal coaching
- Yoga, art, and culinary therapy
- Family-based treatment (FBT) for children/adolescents
- Virtual treatment available statewide

ACCEPTED INSURANCE PLANS IN OHIO:

- **Aetna**
- **Aetna Better Health of Ohio**
  Ohio Rise)
- **Anthem BlueCross BlueShield**
- **AultCare**
- **Carelon Behavioral Health**
- **CareSource**
- **Cigna Evernorth**
- **Community Health Plan of WA**
- **Humana LifeSynch**
- **Molina Healthcare**
- **Medical Mutual of Ohio**
- **Ohio Healthy**
- **OSU Health Plan**
- **SummaCare**
- **United Healthcare/Optum**
- **University Hospitals**
- **VACCN**

Questions about payment?

We are in network with many insurance plans.
Coverage typically varies by insurance policy. Speak with your insurance provider to learn about services covered by your plan. Call us at 888.364.5977 for assistance.

4 EASY WAYS TO MAKE A REFERRAL:

1. Call For Assessment: **888.272.0864**
2. Fill Out the Online Referral Form:
   emilyprogram.com/for-professionals/refer-a-patient/
3. Fax the Referral: **844.385.4628**
   Use your referral form, or use the Emily Program referral form enclosed.
4. For Concierge Service:
   Contact your Emily Program professional relations specialist via email or phone.

FOR MORE INFO:

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Primary care is often where healing begins — your voice, your vigilance, and your compassion can open the door to recovery.