A "Continuum of Care" Approach To Eating Disorders

By
Stuart Koman, Ph.D.
President and CEO, Walden Behavioral Care

Why are eating disorders so difficult to treat?

Anorexia, bulimia and other eating disorders have proven resistant to traditional treatment. However, our base of knowledge has advanced to the point where few in the healthcare community question the need for an interdisciplinary approach and continuous treatment.

An initial treatment, regardless of how intensive it may be, is never enough. Instead, an evolving "continuum of care" approach shows promise and should, over time, reduce recidivism.

Based on the following common observations, which have profoundly affected the treatment of eating disorders, the "continuum of care" must integrate medical and behavioral treatment, in addition to adjusting the mode of treatment as the patient progresses:

- An eating disorder is both a physical illness and a mental illness. Combining medical treatment with psychological intervention produces results that are superior to those achieved by either approach alone. Medical and psychiatric care must be integrated and the whole patient must be treated.
- No one treatment is effective for all patients with eating disorders. There are many types of eating disorders and there are many causes of eating disorders. Eating disorders can affect men and women, pre-adolescents to seniors, and individuals of all socioeconomic status. Even when patients have the same characteristics, they may react differently to the same treatment.
- The earlier we treat an eating disorder, the better the prognosis for recovery. Yet medical definitions of eating disorders often are restrictive, so many needing treatment fail to qualify for coverage. Patients often have a perverse incentive to get worse so they can get better. However, many insurers have demonstrated flexibility and are broadening their criteria for treatment.
- Co-morbidities are common. Many patients with eating disorders also suffer from post traumatic-stress disorder or depression. Some have obsessive-compulsive disorders or practice self-harming behavior, such as cutting or burning themselves. A dual diagnosis of chemical dependency or alcohol abuse is also common.
- Families should be included in the treatment plan, as involvement increases the probability of recovery.
- Patients who actively engage in making educated decisions about their care, and who are self-directed toward meaningful life goals, are far more likely to follow through with treatment and achieve lasting results.
- Treatment should always be individualized as much as possible. No single program can meet every patient's needs.

- As the patient progresses, treatment should, too. Once patients begin to improve, their treatment should adjust to their changing needs. Likewise, when patients backslide, their treatment should be adjusted accordingly. Such adjustments will encourage progress from intensive treatment to full recovery and a fulfilling life.

These conclusions are based on both common experience and broadly accepted research. Yet the healthcare community in some cases still reacts to eating disorders based on old habits and outdated practices.

The "Whole Health" Approach

Given the conclusions cited, a multidisciplinary team approach is essential for successful treatment of eating disorders. No one professional has the expertise to fill all of the patient's medical and psychiatric needs.

A team that includes professionals with experience in psychiatry and psychology, internal medicine and nutrition, social work, nursing and even recreation is needed to provide the full range of therapy and treatment to help patients develop the skills necessary to gain control of destructive eating behavior, improve their support system, increase self-esteem, and establish a stable foundation for long-term recovery.

A team that works together can develop a treatment plan that takes a "whole health" approach, identifying and concurrently addressing all of the patient's mental and physical needs. Treatment can then be adjusted as the patient progresses.

Team members should not only work together, but also work with the patient and with the patient's outside support staff, including doctors, employers, therapists – and, especially, families.

The "whole health" approach is based on the recognition that eating disorders are complex and require:

- Integrated, concurrent medical, nutritional and psychiatric treatment.
- A combination of different types of therapy, including group therapy, family therapy, individual counseling, dialectical behavioral therapy (DBT) and other methods of treatment.
- Treatment of co-morbidities. Co-morbidities exist more often than not. They should be assumed to exist until their absence can be demonstrated.
- Changing treatment as the patient progresses.

The entire continuum of care should be based on the patient's recovery. Care should be continuously assessed and adjusted to achieve optimal results. Stepping down the level of care as the patient progresses is both more cost effective and beneficial to the patient.

The Continuum of Care For Eating Disorders

Historically, medical doctors typically diagnosed eating disorders, usually at a point when the condition was very advanced. Patients with bulimia, in particular, may be able to hide their disorder for years before it is diagnosed, since they often are average in weight and typically do not physically appear to have a disorder.

Insurance usually paid only for in-patient care with limited out-patient care, or paid solely for out-patient care. However, it was unrealistic to expect patients to make the transition from intensive 24-hour psychiatric care to receiving therapy just once a week, if at all.

Since the late 1980s, the "continuum of care" approach has evolved for treating many illnesses. In part, it is a byproduct of managed care. For many illnesses, the trend has been toward a decrease in the length of hospital stays, but with more transitional care. For eating disorders, the move from intensive psychiatric care to out-patient therapy generally has become more gradual, which benefits patients, but also costs less, because less time is spent in hospitals or residential settings. Because this approach is more effective, it also improves outcomes; lowers recidivism and reduces costs.

When more transitional treatment options are available, treatment can also be individualized. Each patient can be directed to the most cost effective treatment that is also clinically appropriate. As with any behavioral disorder, different people need different things. Many patients with eating disorders may not, for example, need to be hospitalized. The result is improved outcomes at lower costs.

The continuum of care approach is still evolving for eating disorders; it is still talked about more often than it is practiced, although progress is clearly being made.

The continuum should be flexible and the hierarchy of care should depend on the patient's needs. A patient who is suicidal, for example, should receive psychiatric treatment even as medical stabilization begins, while a patient who does not have a medical crisis may first seek treatment in a general hospital, then begin specialized treatment at the intensive behavioral care level.

The key at each stage is to neither under-treat nor over-treat patients, but to monitor patients continuously and adjust their treatment based on their condition at any given time. Hopefully, the patient will advance through the continuum, but recovery from an eating disorder is not easy. In some cases, patients will slip back to a level from which they previously advanced.

As healthcare providers have developed a greater understanding of eating disorders, specialized healthcare facilities have developed for treating them. However, only a handful provide intensive in-patient medical treatment, which is necessary for patients with advanced disorders. Fewer still provide a complete continuum of care, which would potentially include all of the following (*see chart*):

Intensive Medically Complex Care (IMC). The first step for anyone with an advanced eating disorder is to achieve medical stabilization. Eating disorders can result in severe medical complications. They can damage a person's brain, liver, kidneys, heart, GI tract, bones, teeth, skin and hair. They can result in osteoporosis, retarded growth, kidney problems, ulcers and heart failure. They can also lead to death. The National Institute of Mental Health found that 15- to 24-year-old females diagnosed with anorexia are 12 times more likely to die than those without anorexia.

Patients needing medical stabilization typically meet one or more of the following criteria, some of which are based on guidelines established by the American Psychiatric Association (APA):

- Medically unstable vital signs, such as:
  An ECG with acute changes caused by electrolyte disturbance, ischemia or other factors
  Hypotension (BP systolic < 80 mm Hg when they are lying down and resting).
  Orthostatic changes in vital signs three minutes after changing positions from lying down to standing (BP systolic drop of 10 mm Hg or more; pulse increase of 20 beats per minute (bpm) or more)
  Body temperature below 96° F.
- A seriously abnormal lab value in any of the following areas: Na+ <125 mEq/L, K+ <3.0 mEq/L, C1 <86 mEq/L, CO2 <20 or >35 mEq/L, BUN >25, serum creatine >2.0, AST >50, ALT >55, albumin <3.0, phosphorus <3.4 for those 20 or younger or <2.5 for those older than 20, magnesium <1.5, calcium <8.0 or >10.7, or glucose <60
- Serious arrhythmia with any degree of heart blockage (after 24 hours of telemetry monitoring), junctional bradycardia, sinus bradycardia (<50 bpm) or prolonged QTc and a need for antipsychotic medications
- Dehydration (5% to 10%, defined by a decrease in skin turgor, increased respiratory rate, postural hypotension, high urine SG or delayed capillary refill of 1.5 to 3.0 seconds)
- Medical complications that require intensive monitoring, such as intestinal atony with an obstruction, nutritional anemia, impaired renal function, fluid imbalance or an exercise-induced injury
- Nutritional requirements that must be met immediately, due to pregnancy, diabetes or other complications

Patients in this category also typically suffer from extreme depression, anxiety, obsessive-compulsive disorder or other psychiatric disorders that make it difficult for the patient to focus on treatment for an eating disorder without 24-hour care.

Criteria for the eating disorder may include multiple daily binging and purging that significantly impairs daily functioning (GAF <50-55) or absorption of needed medication; acute food refusal, or lack of success in restoring weight (treatment in a less-structured program for up to two weeks, during which weight continues to decrease, or for up to three weeks during which the patient has minimal success restoring weight).

While a patient's weight is an important criterion for diagnosing eating disorders, the commonly used standard of 75% of ideal body weight (IBW) is inappropriate in many cases. For short women, in particular, body mass index (BMI), which measures weight adjusted for height, is a much better measure. Patients typically are admitted it they have a BMI less than 16.

For a motivated patient, medical stabilization can take as little as a week, but it typically takes closer to two weeks. A patient with anorexia, for example, cannot immediately resume the normal diet needed to return her or him to good health. Re-feeding takes place gradually and is medically monitored.

Until patients are medically stable and no longer in danger of severe medical crises, they are not functioning at a level where they can successfully engage in psychotherapy. Once they are stable, vital signs are monitored, eating patterns are established and work begins on motivating the patient to want to receive treatment.

While patients at this level are not yet ready for significant behavioral therapy, behavioral goals are set and basic coping skills are taught.

IMC, which is the first of three in-patient care categories, is appropriate only for individuals who are medically and behaviorally unstable and cannot be treated successfully with a lower level of care. Those with co-existing psychiatric or substance use disorders may require psychiatric care or addiction treatment before even beginning care in an eating disorders program.

Given that the ultimate goal is lasting recovery, discharge planning begins even at this stage and continues at every other stage in the continuum.

Intensive Behavioral Care (IBC). IBC is an evolving stage of treatment that integrates intensive psychiatric care with continuing medical care. Patients may progress from IMC to IBC, or new patients who are medically stable may begin treatment at the IBC level.

Patients at this level have medical symptoms and lab values higher than those required for IMC. Intravenous fluid and naso-gastric tube feeding are not needed, and the patient must be able to eat food totaling 1,800 calories or more a day.

Although patients in IBC have achieved medical stabilization, they continue to be unable to control their eating disorder without significant assistance. However, at this stage the patient is capable of engaging in self-care and is ready to begin the recovery process. Medical monitoring and 24-hour nursing supervision continue to ensure that the patient remains medically stable. Physician visits take place twice per week instead of daily, and vital signs are monitored daily instead of two or three times a day.

Key goals at this level are for the patient to stop all eating disordered behavior and to restore normal weight. Psychiatric treatment of co-morbid conditions begins and is integrated with treatment of eating disorders. However, if the patient's psychiatric

condition is so severe that a secure (i.e., locked) setting is required, the patient cannot enter IBC until the psychiatric condition improves. The patient also begins to learn to become self-sufficient and to manage healthy eating habits.

Individuals who have been starving themselves, or binging and purging for a long period of time will take some time before they begin functioning normally. By combining psychotherapy, relaxation therapy, nutritional counseling and other forms of treatment, patients at this level take a major step toward recovery.

Residential Care. Residential treatment works best as part of the continuum of care, rather than as a separate, all-encompassing treatment program.

In the past, residential care was widely used for addiction treatment, but has been widely viewed as an inefficient form of treatment. That's because residential programs typically prescribed the same length of stay and same treatment for all patients. Different people respond differently to treatment and are at differing levels of recovery – so who's to say that a 30-day program is needed for all patients? It may result in over-treatment for some and under-treatment for others.

One benefit of residential living is that it begins to integrate patients back into the community. They may dine at restaurants, go grocery shopping and try cooking, all leading to a healthier relationship with food. Patients also benefit because residential settings typically are comfortable and inviting, not sterile like the typical institutional setting. This can aid in the recovery process by putting patients in a more positive state of mind.

Patients in a residential setting develop and solidify healthy eating and living patterns with an orientation toward recovery. They develop intermediate range goals and plans, as well as behavioral goals and coping skills.

In line with the transitional nature of residential care, monitoring decreases. Nursing supervision is daily rather than 24-hours a day, but a mental health professional is on-site at all times. Medical consultations take place twice a week or as needed, while vital signs are monitored twice per week.

Behavioral and nutritional therapy continues to be intensive, but the focus is more heavily toward recovery than it is during IBC. The structured program may include a daily check-in to assess how everyone is doing, psychological and medical education, cognitive behavioral therapy, dialectic behavioral therapy and discussions on topics such as body image, stress management, cultural issues, family issues and the stages of change.

Partial Hospitalization Program (PHP). Partial hospitalization enables patients to maintain some degree of normalcy, while receiving treatment for their eating disorder. Patients return to active involvement in the community and with family, returning home at night and during weekends, but they receive structured treatment during the day.

To progress from in-patient care to PHP, the patient must meet the following criteria:

- Medically stable vital signs, including:
  An ECG without acute changes
  BP baseline >80 mm Hg while at rest
  Minimal orthostatic BP and P changes, where the changes are not associated with eating-disorder symptoms
  Body temperature >96° F. and <99° F.
  Heart rate >55 bpm
- Lab values that do not meet criteria for in-patient admission
- At least 75% of ideal body weight or a body mass index (BMI) >16, whichever is higher

At this level, eating disordered behavior continues to impair how the patient functions at work or school, and in family and social settings. There is also evidence that the patient needs a structured program to return to a healthy, acceptable weight and to control abnormal eating behavior. The patient either shows ambivalence toward long-term recovery or has difficulty adjusting fully to a complete nutritional eating plan.

Patients in PHP eat structured meals, and develop and reinforce coping strategies for healthy living. More attention focuses on relapse prevention. PHP may include individual, group and family therapy; pharmacology; exercise and other physical activities; occupational therapy; development of new skills; education about eating disorders and nutrition, and more.

To be treated at this level, individuals must be able to eat at least 1,800 calories per day, and must be willing to complete two meals and one snack during program hours. They also must be able to interact in group therapy, able and willing to follow team recommendations for weight and health rehabilitation, and able to make progress in an outpatient setting.

Intensive Out-Patient Care (IOP). Out-patient care begins only when the patient is ready to support herself or himself. Cognition must be normal, and the patient must be moderately to highly motivated.

To progress from PHP to IOP, the patient must show continued improvement, including:

- Medically stable vital signs, as with PHP, but also:
  BP baseline >90 mm Hg while at rest
  Orthostatic changes in vital signs three minutes after changing positions from lying down to standing (BP systolic drop of <10 mm Hg; pulse increase of <20 beats per minute)
- At least 80% of ideal body weight or a body mass index (BMI) of 17 or more, whichever is higher

During IOP, routine monitoring no longer takes place, but the patient continues contact with a clinician at least three times a week. The patient also must have at least one

supervised meal a day for three to five days a week and two hours of non-meal programming a day.

Programming includes individual and group therapy. IOP also includes psychotherapy and support, ongoing education about coping strategies and relapse planning.

Community Based Out-Patient Care. When a patient is approaching or has achieved full recovery, less intensive out-patient care is needed. At this point, the patient is re-integrated into the community and specialized care from an eating disorder program is no longer needed. However, ongoing therapy is still needed to monitor the patient and reinforce what was previously learned.

Even if the patient has fully recovered, ongoing therapy helps prevent individuals from falling back into bad habits, especially when they have excessive stress or encounter personal problems.

Ideally, a single institution should offer all of these levels of care, except community based outpatient care. If the patient has to move from one institution to another, overlap or gaps in treatment are likely. Every time the patient moves to a new institution, healthcare staff must start over and gain the patient's trust. Individuals with eating disorders often have anxiety and are not trusting, so healthcare staff must work hard to gain that trust. A consistent, ongoing team of healthcare personnel can provide continuity and treat the patient more efficiently.

In addition, when one institution offers the complete continuum of care, the healthcare team treating the patient has the flexibility to move the patient between services as needed. Allowing clinicians to customize treatment can result in a more cost-effective program and a better prognosis for the patient.

Characteristics Of A Continuum Of Care

While we've described the stages of a continuum of care for treating eating disorders, a "best practices" approach should include the characteristics developed by Kenneth Minkoff, M.D. as a model for treating patients with co-morbidities. Similar work was performed at Choate Health Systems, which I co-founded. Dr. Minkoff served as Medical Director at Choate.

Although developed for mentally ill patients who are also chemically dependent, it applies well to patients who suffer from eating disorders, especially when there are co-morbidities.

Dr. Minkoff's Comprehensive Continuous Integrated System of Care (CCISC) model, which has been used in practice since 1998, incorporates the following characteristics:

1. **System Level Change**. The continuum of care must be an entire system of care. Applying it to an individual program or training initiative is insufficient. All programs should be designed to become capable of treating co-morbidities.

2. **Efficient Use of Existing Resources.** The model should be implemented using existing resources, however scarce. Implementing a continuum of care approach should not require new funding or new staff; however, Dr. Minkoff assumes that the institution already provides all of the services necessary to create a continuum of care. With eating disorder treatment, that is often not the case.

3. **Incorporation of Best Practices.** The CCISC model incorporates best practices, based on both evidence and clinical consensus. Patients with co-occurring disorders have a wide range of disorders and needs; treatment should integrate best-practice treatment for each disorder.

4. **Integrated Treatment Philosophy.** The model is based on principles of successful treatment derived from valid research and incorporated into an integrated philosophy using a common language that applies to the treatment of both eating disorders and psychiatric disorders.

CCISC also incorporates the following principles, which Minkoff says are necessary to provide "a welcoming, accessible, integrated, continuous and comprehensive system of care" to patients with co-occurring disorders:

1. **Co-morbidity is an expectation, not an exception.** The team treating the patient must always be prepared to treat co-morbidities, whether or not they exist.

2. **Successful treatment is based on empathic, hopeful, integrated and continuing relationships.** Every patient's needs are different. Treatment is not an exact science. Successful treatment, however, typically has the common characteristics of empathy, hope, integrated care and continuing treatment. Ideally, the continuum of care is provided by a single organization with a consistent case manager.

3. **Treatment must be individualized using a structured approach to determine the best treatment.** The national consensus "four quadrant" model for categorizing individuals with co-occurring disorders can be a first step to organizing treatment matching. The model categorizes patients into four quadrants, based on the severity of each disorder. Substituting eating disorders (ED) for problems with substance abuse, the quadrants appear as follows ("MI" means mental illness, "ED" means eating disorders):

Both High Severity	**MI Low Severity** **ED High Severity**
MI High Severity **ED Low Severity**	**Both Low Severity**

4. **Case management and clinical care must be properly balanced with empathic detachment, opportunities for empowerment and choice, contracting, and contingent learning.** The model says that the identified care that is common for each disorder must be balanced with contingent learning, which is based on trying additional treatment based on past experience, patient history and other factors.

5. **When mental illness and eating disorders co-exist, each disorder is "primary," requiring integrated, properly matched, diagnosis-specific treatment of adequate intensity.** When a patient has a dual diagnosis, neither disorder should be given precedence over the other. Again, treatment of the whole patient, with concurrent consideration of both disorders, is required.

6. **Both serious mental illness and eating disorders are primary biopsychosocial disorders that can be treated in the context of a "disease and recovery" model.** Treatment must be matched to the phase of recovery for each disorder.

7. **There is no one correct approach to treating individuals with co-occurring disorders.** Again, different people have different needs. Each patient's case should be considered individually, and a treatment plan should be developed and implemented by a team of professionals, based on best practice requirements – but with enough flexibility to adjust to the patient. Whatever the patient responds best to is the best plan for treating the patient.

The continuum of care for eating disorders is still evolving, but Walden Behavioral Care is already experiencing success with the approach outlined here.

Stuart Koman, Ph.D. is President and CEO of Walden Behavioral Care in Waltham, Mass. He is a Principal of Koman Associates and MVP Research Group, two consulting companies that provide organizational consulting to senior leaders in business and healthcare. He co-founded the former Choate Health Systems.

Sources:

Minkoff, Kenneth, MD, Christie A. Cline, MD, "Changing The World: The Design And Implementation Of Comprehensive Continuous Integrated Systems Of Care For Indivdiuals With Co-Occurring Disorders," Psychiatric Clinics of North America, 27(4):727-43 © 2004 (http://www.kenminkoff.com/articles.html)

Minkoff, Kenneth, MD, "Program Components Of A Comprehensive Integrated Care System For Serious Mentally Ill Patients With Substance Disorders," In: Minkoff K, Drake RE, eds. Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services, No 50. San Francisco, CA . Jossey- Bass, 1991 pp13-27

Minkoff, Kenneth, MD, "Psychopharmacology Practice Guidelines for Individuals with Co-occurring Psychiatric and Substance Use Disorders (COD)," Based on the psychopharmacology guidelines in Minkoff (2001), "Service Planning Guidelines for Co-occurring Psychiatric and Substance Disorders," Illinois Behavioral Health Recovery Management Project, January, 2005 (http://www.kenminkoff.com/articles.html)

The National Institute of Mental Health (http://www.nimh.nih.gov/publicat/eatingdisorders.cfm)

Sullivan PF. Mortality in anorexia nervosa. American Journal of Psychiatry, 1995; 152(7): 1073-4.