Residential Eating Disorders Consortium

INTERNAL REDC DOCUMENT NOT FOR EXTERNAL DISTRIBUTION
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Internal Q&A

Note: This document is for internal use only to assist treatment centers in responding, on a case-by-case basis, to questions they may get asked. It is not intended to be distributed externally as a unified document. It is expected that facilities utilizing this document will customize answers as appropriate to reflect accurate facts related specifically to their facilities.

Money

1) **You are a for-profit entity. Critics say the "profit motive" may lead you to sacrifice quality for profit. How do you respond?**

   Eating disorders are complex and lethal illnesses: An American dies roughly every hour as a direct result of one. 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.

   Our top priority is helping the patients in our care recover from their illnesses and lead productive and fulfilling lives. This priority directs all of our decisions.

   We are grateful to be able to provide services that are so badly needed in this community. We firmly believe that we owe it to the families we serve to have a solid business model that provides stability, continuity, accountability, and the highest quality care in a stable environment for patients—and also enables us to be good citizens in the community at large. Being a for-profit entity means that we are an important contributor to the tax base in the communities in which we operate. Our business model also allows us to invest in the community in the form of scholarships, community education, and charitable giving, and invest in the state of the art, evidenced-based practice, training, and facilities. This provides a safe, secure, and inviting treatment environment for our patients—and makes us an asset to the community.

2) **You now have an investor. Critics say investors mostly care about the bottom line. Has your investor pressured you to change your priorities or the way you do business?**

   The standards we must meet, and the clinical practices necessary to meet those standards, are unchanged. Our top priority is helping the patients in our care recover from their illnesses and lead productive and fulfilling lives. This priority directs all of our decisions.

   In the eating disorders industry, an increase in much-needed private investment has expanded the availability of resources and access to care across the country for patients desperately in need of

treatment. Many people are not aware that in the United States and around the world, there is a huge deficit of resources to treat eating disorders. Only about a third of people with an eating disorder ever receive treatment. Among adolescents with eating disorders, less than 1 in 5 receives treatment.

Investment in our industry has helped narrow the gap between demand and supply for eating disorders treatment. In XXXX, treatment was only available in X states. Today it is available in X states.

Furthermore, we firmly believe that we owe it to the families we serve to have a solid business model, including being well-capitalized, that provides stability, continuity, accountability, and the highest quality care in a stable environment for patients—and also enables us to be good citizens in the community at large. Being a for-profit entity means that we are an important contributor to the tax base in the communities in which we operate. Our business model also allows us to invest in the community in the form of scholarships, community education, and charitable giving, and to invest in the state of the art, evidenced-based practice, training, and facilities.. This provides a safe, secure, and inviting treatment environment for our patients—and makes us an asset to the community.

3) **Because you are for-profit, are you incentivized to admit people for residential treatment even if they don't need it?**

Our motivation is to make sure that patients get the care that is appropriate for them so that they can recover from their illnesses and lead productive and fulfilling lives. This motivation directs all of our decisions.

We strictly adhere to guidelines from the American Psychiatric Association (APA) regarding the appropriate levels of care and are committed to treating at the least restrictive level of care to meet a patient's needs.

We take our obligations to care for vulnerable patients extremely seriously. In fact, we voluntarily joined the Residential Eating Disorders Consortium (REDC), a national professional association of residential eating disorders treatment providers that has been at the forefront of raising industry standards. REDC has a "Center of Excellence" document that outlines what best-practice care in our industry looks like. This document, which we uphold, expressly states that treatment centers should be transparent about whether and how their offerings match the patient's needs and committed to providing a seamless experience to patients who may need to transfer to other levels of care. It says that treatment programs will guide patients to alternative treatment resources if they are unable to provide clinically appropriate care for the patients. These are our commitments to the community and to the REDC.

4) **Some facilities charge $1,000 a day or more. Does this give legitimacy to the claim from some critics that your industry is preying on vulnerable families?**

Eating disorders are complex and lethal illnesses that require the coming together of two simultaneous and very distinct fields of treatment—medical and psychological. This treatment must be provided by thoroughly trained and highly specialized professionals in multiple disciplines, including MDs, nurses, psychiatrists, therapists, dietitians, and more. In addition, many individuals with an eating disorder also suffer from a co-occurring disorder. It is actually a cost-effective alternative to inpatient hospitalization for our patients – i.e., patients with severe EDs who are relatively medically stable but not able to recover with lower level of care. Residential treatment is an extremely cost effective intervention for what the patient receives and can dramatically reduce mortality and chronicity.

We are committed to treating to providing the best treatment we can and to working with patients to ensure that financial constraints do not become a barrier to care. At (facility name), we advocate for patients in making sure that they can access all health-insurance benefits due to them. Where patients have no insurance, limited insurance, or constrained financial resources, our program has financial assistance programs in place to assist. In addition, we are also well-informed about independent nonprofits and other organizations that administer need-based opportunities for financial assistance, and where appropriate, we connect patients with such organizations.

In addition, we are a member of the Residential Eating Disorders Consortium (REDC), a national professional association of residential eating disorders treatment providers that has been at the forefront of pushing to make sure families from all socioeconomic backgrounds have greater access to care. These efforts include successfully advocating for the passage and signing of the 21st Century Cures Act, which includes provisions of the Mental Health Reform Act of 2016 and the Anna Westin Act of 2015. The law includes provisions to improve early identification of eating disorders by health professionals and to expand treatment coverage of eating disorders by explicitly clarifying that the Mental Health Parity law applies to residential eating disorders treatment.

5) How do you help patients understand their financial obligations? What are your billing practices?

Providers in our industry often must admit patients without full information about what payors 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, we do everything in our power to ensure that patients 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.

To that end, we are committed to being transparent with all stakeholders in shaping expectations about realistic outcomes of treatment. We have honest conversations about recidivism rates and the typical illness duration and course of care that may be required over a patient's lifetime. We use a transparent process to assess a patient's or family's ability to meet its financial responsibilities and

apply financial-need assessments fairly and equitably across patients. When patients have no insurance, limited insurance, or constrained financial resources, we have financial assistance programs in place to assist. In addition, we are also well informed about independent nonprofits and other organizations that administer need-based opportunities for financial assistance, and where appropriate, we connect patients with such organizations.

(If not covered by the above, describe your programs additional processes for equipping patients and families to manage their financial responsibilities for treatment.)

Marketing

6) **The marketing practices of this industry have come under fire. Critics say the industry is marketing spa-like atmospheres and ocean views. How do you respond?**

Eating disorders are complex and lethal illnesses and should be handled as such. As an organization that treats these illnesses, we pledge to uphold nothing short of the highest standards of conduct in both our clinical approach and our business practices. This includes adopting marketing practices that are educational and focused on treatment, consistent with—and truly representative of—our operational focus on best-practice care.

The environments are designed to be welcoming, with principles of healing design integrated in our facilities, as is the case with many health care facilities. Our patients, who are beginning the process of recovery from a severe, potentially fatal eating disorder, are undergoing one of the most strenuous experiences they may ever experience. We believe a comfortable setting may mean the difference of someone giving up on this daunting, exhausting process or sticking it out so that they can get well.

We take this commitment very seriously. In fact, we voluntarily became members of the Residential Eating Disorders Consortium (REDC), a national professional association of residential eating disorders treatment providers that has been at the forefront of raising industry standards. REDC has a "Marketing Best Practices" document that outlines what best-practice marketing in our industry looks like. We adhere to these guidelines.

Consistent with the REDC marketing guidelines, at (facility name), we evaluate our marketing messages to ensure that they communicate substantive, critical information about our therapeutic services and arm patients and families with information that allows them to make informed treatment choices. Our messaging has treatment as its primary focus.

7) **Do you pay for referral sources to fly in and tour your facilities? Provide lavish meals and entertainment? Host fancy banquets throughout the year. Why or why not?**

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We take this commitment seriously. In fact, we voluntarily became members of the Residential Eating Disorders Consortium (REDC), a national professional association of residential eating disorders treatment providers that has been at the forefront of raising industry standards. REDC has written "Marketing Best Practices" guidelines, which we follow, that state:

> *The average physician only receives an estimated four hours of eating disorders training in his or her entire medical education. That is woefully inadequate. If left untreated, eating disorders frequently result in costly medical complications and may result in death. Individuals who have access to and receive appropriate care often fully recover and go on to lead productive lives. Yet the vast majority of individuals suffering from eating disorders do not receive the care they need.*
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> *To that end, REDC members look for opportunities, including site visits, to educate health professionals in need of training in eating disorders early identification, treatment, and referral—with the goal of saving lives.*
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> *We have found that it is critical for health professionals to gain an understanding of how to identify eating disorders, see with their own eyes the treatments being offered, meet the clinicians who could assist their patients in need, and evaluate whether a program's treatment philosophy aligns with their own. We also recognize that providers visiting our site/s must take a day off work, cancel their patients for a day and incur the inconvenience of travel. Thus we believe it is entirely appropriate to cover sensible out-of-pocket costs.*
>
> *REDC members are committed to structuring site visits as opportunities for education, not entertainment. REDC's policy is that reimbursement for travel, accommodations and meals should pass a "reasonableness" standard. REDC's "no-entertainment" policy holds that in general, activities should occur on site. When treatment centers host a reasonable off-site gathering as a legitimate marketing function, they are transparent with providers and referral sources that it is a marketing activity. Lavish dinners and "experiential" activities, such as harbor cruises, helicopter rides, and golf outings, should be avoided. With regard to all of the above, a useful question to ask is: "Is this activity educational or a benefit to providers professionally?"*

555 8th Avenue, Suite 1902
New York, NY 10018
646-553-1340

8) **REDC's "Marketing Best Practices" document refers to a suggested $25 limit on gifts. But research shows that even nominal gifts like pens can have undue influence. Is REDC's policy suggesting that it's okay to give gifts?**

REDC's policy states the following: "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 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. In marketing their services, REDC members are committed to relying upon objective facts and open, honest communication—not gifts—as a way to engage stakeholders. Gifts are never used to gain any special advantage in a business relationship."

9) **Why didn't REDC suggest an outright ban?**

REDC strongly discourages the giving of substantial gifts. It also states a preference for items that have a purpose or intent related to education and assisting treatment, such as a book or workbook. We believe that these two guideposts—items of only a nominal value and a preference for items that have a purpose or intent related to education and assisting treatment—offer a clear policy that in marketing their services, programs should rely upon objective facts and open, honest communication, not gifts, as a way to engage stakeholders. Gifts are never to be used to gain any special advantage in a business relationship.

10) **When referral sources visit your sites, why do you offer continuing-education credits for free? Is that meant as just another "sweetener" to entice referrals?**

Health care providers have wide discretion in choosing topics to meet their continuing-education requirements. It's a bit like choosing electives in college. Eating disorders are widespread and lethal, yet we know that most physicians only receive an estimated four hours of eating disorders training during the course of their entire medical education. We feel strongly that every health care provider needs eating disorders training, and we are committed to increasing education and awareness through every available and appropriate channel. That is why we offer continuing education to some site visitors at no charge. We adhere to strict standards and criteria imposed by sponsoring agencies to provide continuing education credits and are bound to the ethical standards of those agencies to provide education that is free of bias. I will point out that we also offer free continuing-education credits at locations that are unrelated to site visits, such as in community centers and libraries.

11) **Some say the industry markets itself with wild claims about success rates. What do you tell patients?**

We are committed to being transparent with all stakeholders in shaping expectations about realistic outcomes of treatment. We have honest conversations about recidivism rates and the typical illness duration and course of care that may be required over a patient's lifetime.

Metrics

12) Eating disorders are challenging to treat. They are complex illnesses with high relapse rates, somewhat uncertain outcomes, and a need for more data. In this environment, how do you measure success?

As demand for eating disorders treatment has soared and the field has evolved, there is a pressing need for reliable, consistent data collection to track outcomes and make it possible to evaluate eating disorders treatment programs based on national benchmarks. Such information is of key interest to care providers, patients, families, insurance companies, regulators, elected officials, media, and other stakeholders. While there is considerable consensus among practitioners and researchers on which metrics are most meaningful, data collection is inconsistent, and some metrics are redundant or overlapping.

Despite these challenges, we use a number of tools—including metrics recommended by The Joint Commission and CARF—to collect and report the following: weight, eating disorders behavior change, anxiety, depression, and quality of life. We have instituted a rigorous process for measuring these outcomes upon admission, at discharge, at six months after discharge, and at 12 months after discharge. We achieve participation rates of 60 percent to 70 percent at discharge to ensure data robustness and validity, and we have a system in place and make every effort to collect data at six and 12 months post-discharge as well. We also track, to the extent possible, post-discharge treatment services received by the patient. (Describe any partnerships your facility has with academic-based research programs or other reputable researchers to establish a high-quality outcomes-measurement collection system.)

In addition to tracking clinical/patient outcomes, we also utilize quality and process-improvement metrics, including patient and family satisfaction, average length of treatment, readmission rates, and follow-up service after discharge. Of utmost importance is patient safety. We embrace a philosophy of continuous process improvement and put in place systems to track results.

On a broader, industry-wide view, we feel strongly about this issue. In fact, we voluntarily became members of the Residential Eating Disorders Consortium (REDC). REDC is a national professional association of residential eating disorders treatment providers that has been at the forefront of raising industry standards and calling for reliable, consistent data collection to track outcomes and make it possible to evaluate eating disorders treatment programs based on national benchmarks. We participate in multi-site studies and partner with academic-based research programs to ensure that in the future, it will be possible to have reliable benchmarking across the eating disorders treatment industry.

Methods

13) The industry has been accused of using untested therapies and unproven outcomes. Is that a fair assessment? And what is your stance on evidence-based treatment?

We believe that clinical services offered to patients should be grounded in a three-pronged approach: scientific evidence published in peer-reviewed journals, clinical expertise considered practice-based evidence, and patient preference. Our treatment is firmly grounded in research, while also focused on spurring new innovations in practice.

We continually review the most recent findings in eating disorders etiology, development, and treatment to ensure that our treatment is up to date and evolving as the evidence expands. We 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, we cultivate an employee base that is highly knowledgeable and trained in current industry trends, including those related to age, culture, and gender.

The established evidenced-based practices of Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Family-Based Treatment (FBT), nutritional rehabilitation, weight restoration of at least two pounds per week on average when needed, and medical and psychiatric management inform the primary treatment services we deliver.

Clinically, first-line outpatient treatments work for many, but not all, patients with eating disorders. A significant proportion of patients will require a higher level of care. We acknowledge that research on these higher-level-of-care interventions—such as residential, partial hospital programs (PHP), and intensive outpatient programs (IOP) —is limited, and that the evidence base must be expanded through further research to fully understand what works and for whom. That is why we pursue research collaborations with interested researchers to bridge the research-practice gap and contribute to the advancement of knowledge in the field. We look for opportunities to collaborate with universities and scholars to validate field best practices, publish findings in peer-reviewed journals, and hold the field accountable for tracking and reporting outcomes in a consistent way.

14) Why don't you accept Medicare, Medicaid and TRICARE?

There is a great deal of misinformation and confusion about this point, and we welcome the opportunity to offer clarity.

First, hospital programs can – and legally must – accept Medicare and Medicaid, and some (inpatient) facilities accept TRICARE. However, free-standing psychiatric facilities of a certain size are excluded from coverage by statutory language under Medicare and Medicaid, thus limits our ability to accept these plans.

15) What proof is there that residential treatment is better than outpatient treatment and/or other levels of care?

It's not about one being better than the other. It's about making sure that patients get the level of care that is right for them at any given moment in time. Eating disorders are complex and potentially lethal illnesses that sometimes involve a prolonged course of treatment, or multiple courses of treatment, over a patient's lifetime. Residential care is required for patients with severe eating disorders who are unable to respond to lower levels of care.

We strictly adhere to guidelines from the American Psychiatric Association (APA) regarding the appropriate levels of care and are committed to treating at the least restrictive level of care to meet a patient's needs. We are transparent about whether and how our offerings match the patient's needs and committed to providing a seamless experience to patients who may need to transfer to other levels of care. We guide patients to alternative treatment resources if we are unable to provide clinically appropriate care for them.

Successful recovery depends on access to the full range of treatment options, including the residential level of care. In many cases, adequate inpatient, residential, and partial hospital treatment, with sufficient outpatient follow-up, is absolutely necessary to achieve a full recovery. Treatment ideally is delivered in the least restrictive setting possible to safely meet the psychological, psychiatric, medical, and nutritional needs of the individual. For example, the residential level of care serves to address the needs of patients who require extended treatment for adequate symptom management and recovery of weight and health parameters, but who do not require many of the services provided in the inpatient setting (e.g., intravenous fluids, tube feedings, and multiple daily lab tests). In fact, residential care is often able to provide more robust psychological eating disorder treatment at a lower cost than inpatient hospitalization so may be a better fit for a patient that does not require a high degree of medical intervention.

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