



Defining an Eating Disorders Center of Excellence

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Introduction

Eating disorders are biologically based mental illnesses that affect an estimated 30 million Americans of all ages, genders, socio-economic statuses, and ethnicities. 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.

For these reasons, the work of the eating disorders field is critical, and there is an urgency to set a clear definition of what constitutes excellence in eating disorders treatment. The Residential Eating Disorders Consortium (REDC), a professional association of residential eating disorders treatment providers created in 2011, authored this article to articulate the standards that treatment programs must meet to qualify as an eating disorders Center of Excellence (COE).

REDC was founded, in part, based on the recognition that the eating disorders field is at a crossroads moment. In a short time, the field has seen a number of rapidly changing dynamics, including a greater awareness of eating disorders and reduced stigma for seeking treatment, such that demand for treatment has outstripped supply; mental health parity rules and Affordable Care Act provisions that require insurance companies to cover more treatment, spurring growth in the industry; and an increase in much-needed private investment that has helped expand services. With all of this growth comes a pressing need for outcomes-data collection and research that is consistent, reliable and scientifically valid.

Against this backdrop, we have seen that voices from within the eating disorders treatment industry itself can be a powerful force in raising the standard of care for how eating disorders are treated. Key REDC members and leaders — along with the Academy for Eating Disorders (AED), the National Eating Disorders Association (NEDA), and the International Association of Eating Disorders Professionals (iaedp) — were integrally involved as the Commission on Accreditation of Rehabilitation Facilities International (CARF) released standards for accrediting eating disorders treatment programs in the *2013 Behavioral Health Standards Manual*. This marked the first eating disorders-specific accreditation in behavioral health care. Continued advocacy directly led to The Joint Commission also establishing accreditation requirements, which took effect July 1, 2016, for behavioral health care organizations that treat patients with eating disorders. These were critical steps in providing accountability. Also in 2016, the Eating Disorders Coalition, REDC and other leaders in the eating disorders treatment industry succeeded in their efforts to see the 21st Century Cures Act — which includes provisions of the Mental Health Reform Act of 2016 and the Anna Westin Act of 2015 — become law. The 21st Century Cures Act includes measures to improve early identification of eating disorders by health professionals and to expand treatment coverage of eating disorders by explicitly clarifying that the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to eating disorders treatment, including residential.

But there is more work to be done. Licensing requirements vary widely among states, making it difficult to compare licensure compliance requirements across state lines. At the national level, while there is considerable consensus on which metrics are most meaningful, data collection is inconsistent, and some metrics are redundant or overlapping. This makes national benchmarking of eating disorders treatment programs difficult or impossible.



Our hope is that this document becomes an important reference for eating disorders treatment programs that aspire to be best-in-class and seek a blueprint for such success, for patients and families making treatment decisions, and for the wider array of stakeholders — including insurance companies, regulators, media, and others — who seek a concrete understanding of what best-practice care looks like.

Attributes of an Eating Disorders COE

The following details the minimum standards that must be met to deliver the kind of high-quality care that warrants a designation as a COE. REDC expects its members to uphold these standards or have a plan in place to meet them expeditiously.

1) Accreditation

REDC has been an outspoken leader in pushing for accountability and standards in the eating disorders treatment industry. As noted earlier, REDC members along with leaders from organizations across the field played key roles as CARF released standards in 2013 that marked the first eating disorders-specific accreditation in behavioral health care, and as The Joint Commission established accreditation requirements effective in 2016 that raised standards for the entire industry.

As a condition of membership in REDC, a residential eating disorders treatment program agrees to maintain accreditation by either The Joint Commission or CARF — meeting the eating disorders provisions in either accreditation, which are similar and based on the same core principles — and meet all state licensure requirements. COEs meet these same minimum accreditation and licensure requirements. REDC will continue to push for clear, strong standards at both the state and national levels, and COEs similarly are expected to be active participants in this ongoing advocacy.

2) Qualified Staff

COEs accurately represent the qualifications of their staff. 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). COEs employ accomplished clinicians who are highly trained and fully credentialed, with the ability to provide developmentally age-appropriate care. COEs ensure that clinicians continue to receive the best training available in eating disorders care as the field advances. Care providers hold the proper degrees and licenses in areas of treatment intervention such as medicine, nursing, mental health, nutrition, etc. Staff includes all of the following: medical management to include MDs, PAs, or APRNs; psychiatric management to include psychiatrists, psychiatric PAs or psychiatric APRNs; psychotherapists and other behavioral and mental health providers; and registered dietitians. All staff are employed by or contracted by the treatment program, or under a formal training arrangement with an educational institution, or under the supervision of a person or persons appropriately experienced or licensed. COEs provide clinical oversight for third-party contractors.

COEs fully embrace their role as the primary training ground for the majority of future clinicians in the field of eating disorders and as providers of continuing education for current practitioners. As such, COEs are committed to providing robust clinical training programs that are of the highest quality.

In addition, COEs recognize that a commitment to continuous education and training begins at home. Thus, COEs foster an environment of continuous learning among their own staffs, dedicating significant resources to ensuring that their own clinicians stay abreast of, and contribute to, the latest research and best practices as the field evolves. In the eating disorders treatment industry, developing talent and expertise from within is paramount. At COEs, employees are given opportunities to enhance their leadership skills and training and to rise in positions of greater scope and responsibility. In addition, COEs are actively engaged in fostering an atmosphere of diversity and inclusion for patients and staff. Ultimately, robust opportunities for staff development create a virtuous cycle, fostering a commitment to excellence,



reinforcing a sense of mission, and thereby strengthening the capacity for the field to offer the highest quality care to the greatest number of patients and families in need.

COEs acknowledge that for staff at all levels and across all roles within an eating disorders treatment program, this is challenging work. Patients and families are under pressure when they present for treatment, numerous factors can make it difficult to make sure patients get adequate care, and there are often few accolades from society for staff who work on the front lines of eating disorders care. COEs recognize the commitment, professionalism and tenacity required of the people working in this field, and COEs look for opportunities to recognize and applaud employees' good work and to actively promote and support staff self-care.

3) Evidence-Based Treatment

COEs 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, 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 preference into account should not be construed as allowing patient preferences to override the clinical expertise/medical judgement of treatment providers. Treatment is grounded in the available research, while also focused on spurring innovations (e.g., from clinical practice, academic literature, and so forth). COEs 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, COEs cultivate an employee base that is highly knowledgeable and trained in current industry trends, including those related to age, culture, and gender.

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. REDC members 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. COEs are expected to pursue research collaborations with interested researchers to bridge the research-practice gap and contribute to the advancement of knowledge in the field.

4) Performance, Quality, & Process-Improvement Measurement Systems

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. COEs seek to conduct research in a manner that minimizes bias in data collection and ensures methodological rigor, and they are urged to complete training in research ethics.

Despite challenges, COEs use every tool at their disposal — including metrics recommended by The Joint Commission and CARF — to track results.

- **Clinical/patient outcomes** that are expected to be collected and reported include: weight, eating disorders behavior change, anxiety, depression, and quality of life. There are multiple metrics options for each of these outcomes. COEs use metrics that best fit the needs of their patients and programs, in keeping with the current literature. COEs institute rigorous processes for measuring these outcomes upon admission, at discharge, at six months after discharge, and at 12 months after discharge. COEs are expected to achieve participation rates of 60 percent to 70 percent at discharge to ensure data robustness and validity, and they are expected to have a



system in place and make every effort to collect data at six and twelve months post-discharge as well. Limitations and potential biases due to decreased response rates for follow-up assessments are expected to be disclosed. We recognize that many COEs treat individual patients who may require multiple levels of care within a program's single encounter with that patient. At a minimum, this requirement means that COEs track outcomes at admission and discharge. COEs are also expected to track, to the extent possible, post-discharge treatment services received by the patient. COEs are expected to conduct high-quality outcomes-measurement collection and reporting or partner with reputable researchers to establish such a system for data collection and reporting. COEs 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.

- **Quality and process-improvement metrics** might include patient and family satisfaction, average length of treatment, readmission rates, and follow-up service after discharge. Of utmost importance is patient safety. COEs embrace a philosophy of continuous process improvement and put in place systems to track results.

COEs are at the forefront in driving the eating disorders treatment industry to encourage every program in the field to consistently collect performance results and be transparent in sharing them. COEs are transparent in providing their specific outcomes data, and accurate in the way that their data are presented to the public. REDC and its members also share the field's vision of a centralized data-reporting system with standardized national benchmarks. To that end, we are calling on the field to evaluate the best way to create such a database, and we look forward to contributing to such a database, once created. The goal is a reliable, consistent process that permits national benchmarking.

COEs are committed to being honest and transparent with all stakeholders in shaping expectations about realistic treatment outcomes. Some of the criticism in this field has been related to hyperbolic claims designed to entice patients away from competitors with false promises and baseless comparative statements. We agree that this is unacceptable. COEs accurately represent their treatment 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). 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.

COEs 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. Furthermore, COEs do not seek to be held to lower outcomes standards with misleading claims that their patient population is somehow different from others. Instead, COEs are committed to informing every incoming patient and family member of the realistic trajectory of treatment. 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 are willing to have these practices studied and validated, such that the entire field can benefit.

COEs 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.

5) Sound and Ethical Business Practices

Sound business practices are a bedrock principle for any program to be effective in treating patients with eating disorders. Those who provide care for vulnerable populations, including eating disorders patients, must pledge



themselves to the highest ethical standards. At all times, they conduct themselves and their businesses in a way that reflects a constant awareness that they are entrusted with the health and lives of people with complex, serious, and potentially fatal illnesses. This commitment begins with admitting only patients that a program can adequately treat given staffing, the intensity of medical monitoring, and the available expertise in all areas of treatment. It also includes adopting marketing practices that are educational and focused on treatment and utilizing billing practices that are fair and transparent. COEs also have business models that provide stability and continuity, including being well-capitalized so that patients can expect and receive quality care in a stable environment.

- **With regard to admissions**, the process of seeking admission to a treatment program is often a critical time for patients and families, confounded with conflicting emotions and confusion due to the very nature of coping with the complexities of an eating disorder. Through the intake and admissions process, COEs commit to full transparency with prospective patients and families.

This transparency includes accurately representing the services and care that their program is capable of providing. During the pre-admission process, a COE carefully considers the multifaceted psychiatric, medical, nutritional, and therapeutic needs of a patient with an eating disorder. A COE performs a comprehensive assessment to determine if it is the best clinical fit for a prospective patient. In addition, a thorough medical and nutritional screening is provided to ensure that the program can effectively treat the nuances of that particular patient. A COE only admits patients whose needs are appropriate for the type of treatment provided — and for the level of care provided — at their programs. 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. A COE admissions department also provides full financial transparency without the inclusion of financial incentives to prospective patients.

COEs disclose any potential conflicts of interest and/or internal or external relationships, financial or otherwise, that their programs have that might affect patient care. If a COE directs a patient from one program to another in which the COE 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.

- **In marketing their services**, COEs employ messaging that is truthful, fair, non-deceptive, capable of being substantiated, and in all respects lawful. Marketing messages from COEs are expected to communicate substantive, critical information about a therapeutic service and arm patients and families with information that allows them to make informed treatment choices. Such messaging has treatment as its primary focus. Promotional messaging from a COE is never simply an enticement to choose one facility over another, nor is it focused on superficial attributes or used as a vehicle for deceptive claims. REDC provides all members with “Marketing Best Practices” guidelines that identify concrete ways for eating disorders treatment programs to ensure that their marketing practices are educational and focused on treatment, consistent with — and truly representative of — programs’ operational focus on best-practice care. These guidelines include:
 - With limited exceptions described in REDC’s policy, not paying or receiving anything of value in exchange for patient business;
 - Adhering to REDC’s “no entertainment” policy, which advises programs to structure site visits of health professionals as opportunities for education or legitimate marketing activities, not entertainment;
 - Ensuring that reimbursement for travel, accommodations, and meals is reasonable;
 - Limiting gifts to items of nominal value, with a preference for items that have a purpose or intent related to education and assisting treatment, such as a book or workbook;
 - Ensuring that all funds expended for education and legitimate marketing activities for business purposes and gifts are accurately documented and reflected in the books and records of the treatment center;



- Complying with laws stating that 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;
- Limiting the use of transportation scholarships and subsidies for patients to cases of genuine, demonstrable financial need — not using these as enticements for patients to choose one facility over another;
- And being honest and transparent with all stakeholders in shaping expectations about realistic outcomes of treatment.

COEs are expected to follow similar guidelines.

- **With regard to billing practices**, prior to admitting a patient, COEs 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, COEs 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, COEs 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.

COEs accurately communicate regarding their prices, expectations about patient out-of-pocket costs, and how long a patient is expected to require treatment. They 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. They 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.

A COE uses a transparent process to assess a patient’s or family’s ability to meet its financial responsibilities and applies financial-need assessments fairly and equitably across patients. When patients have no insurance, limited insurance, or constrained financial resources, COEs have financial assistance programs in place to assist. In addition, COEs are also well-informed about independent nonprofits and other organizations that administer need-based opportunities for financial assistance, and where appropriate, COEs connect patients with such organizations.

6) Full Continuum of Care

COEs strictly adhere to guidelines from the American Psychiatric Association (APA) regarding the appropriate levels of care, and they are committed to treating at the least restrictive level of care required to meet a patient’s needs. Although they may not offer every level of care, they are excellent providers of the levels of care that they do offer, 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. COEs guide patients to alternative treatment resources if they are unable to provide clinically and/or medically appropriate care for the patients. Treatment programs can achieve a seamless experience for patients by both expanding their own programs’ available resources and by partnering with other programs that share their values and commitment to high quality, transparency, and the highest ethical standards. To that end, COEs are constantly working to establish and enhance robust relationships with programs



that are able to provide additional levels of care required by patients. The goal is an integrated approach to treatment that meets the dynamic needs of a patient across the entire recovery journey. Providing for a robust continuum of care increases efficiency and allows COEs to be employer-friendly, consumer-friendly, and good managed-care partners.

To support the gains made in treatment and progress in recovery, every patient should discharge with a proper discharge plan. Case managers are expected to connect patients to affordable, appropriate care to the best of their abilities given the potential resources in the patient's region. To that end, case managers are responsible for establishing a high-quality discharge plan for every patient upon discharge — and communicating that plan to the receiving treatment team. Long-term, post-treatment engagement can offer patients the greatest opportunity for a full and lasting recovery and early intervention if there is a relapse. For family members who themselves require behavioral health treatment, COEs are a resource for connecting to care.

7) Care for Co-Occurring Disorders

Many individuals with an eating disorder also suffer from a co-occurring disorder. These most often include mood disorders, anxiety disorders, substance use disorders, and trauma. For example, research indicates that in some populations of eating disorders patients, the prevalence of mood disorders may be as high as 80 percent. A fully resourced eating disorders treatment program is prepared to accept patients with co-occurring conditions and is equipped to offer evidence-based, appropriate treatment from the necessary psychiatric, medical, and therapeutic staff with demonstrable skills and training to treat these conditions. Staff members providing care for patients with co-occurring disorders are expected to be working under the supervision of a person or persons experienced, trained or licensed to treat the relevant co-occurring disorder or disorders for disorders where such training, licensing and/or certification exists. The aim is for COEs to provide a comprehensive, integrated treatment experience for patients. COEs 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.

Substance Use Disorders

With regard to substance use disorders, in particular, COEs are expected to have a pre-admission screening process to identify which patients qualify for substance use treatment, to have the proper mechanisms in place to refer out patients appropriately, and to be transparent about what treatments for substance use disorders they do and do not offer.

- Centers that treat patients who have a *history* of substance use disorders — but who do not have an active and serious substance use disorder — are equipped, at a minimum, to provide a sober environment and make peer-support groups available. COEs hire or have access to consult with clinicians with documented training in substance use disorders. Such centers also are expected to have a pre-admission screening to assess for active use and withdrawal risk, and to refer out as appropriate. Finally, such centers are equipped to identify signs and symptoms of active addiction, and if a patient is identified to have a re-emergence of or ongoing active addiction, to refer out appropriately.
- In addition to the above, centers that treat patients with *active* substance use disorders also employ evidence-based treatments for substance use disorders, such as medication-assisted therapy; TSF; Motivational Enhancement Therapy; specific DBT or CBT for substance use disorders; and psychoeducation about substance use disorders. COEs hire or have access to consult with clinicians with documented training in substance use disorders. COEs have specific treatment plans designed to actively manage the disease of addiction and foster ongoing recovery. Finally, centers treating active co-occurring substance use disorders have protocols in place to monitor for withdrawal symptoms and either refer out for detox or appropriately treat the withdrawal.



Trauma

Since trauma is a common co-occurring condition with eating disorders, COEs are expected to have a process in place that assesses the potential trauma experiences of patients; to create an environment that both feels and is “safe” for the patient to reveal, share and address their trauma and residual effects; and to put processes in place that assure that the trauma will not be overlooked or ignored. Trauma is addressed properly as an important part of the treatment plan for patients. However, COEs clearly understand that the initial therapeutic focus must be on treating the eating disorder.

That said, COEs are expected to engage in thorough screening for and assessment of trauma. REDC suggests the use of both a therapeutic interview as well as a validated research measure specific to trauma to gauge symptomatology and potential diagnoses. Patients identified as having experienced trauma — and their families when appropriate — are then provided psychoeducation on trauma and its impact on them. Such patients learn and practice grounding and containment skills with their therapist as the basis of any trauma work.

COEs are expected to identify an evidence-based treatment for trauma — such as Trauma-Focused CBT (TF-CBT), Cognitive Processing Therapy (CPT), Exposure Therapy, and/or Eye Movement Desensitization and Reprocessing (EMDR) — and train clinical staff to be able to engage in trauma treatment as the patient is ready to do so. Any remaining trauma work must be identified at the time of discharge as part of discharge planning so that the next-level-of-care treatment team can continue the work.

In addition to the clinical team being trained in an evidence-based treatment for trauma, all members of a COE's staff that have a patient-facing role are educated and trained on "trauma-informed care" protocols. Such knowledge ensures that a COE's environment of care minimizes re-traumatization that can otherwise occur even during treatment.

8) Collaboration with Families

COEs recognize the impact of eating disorders on families and do everything possible to support family members and encourage self-care among family members to ensure their sound mental health. COEs are committed to involving and engaging families and fostering excellent communication with them. Except in cases of maltreatment, psychopathology, etc., COEs include patients' family members and partners whenever possible at every stage of the process, including pre-admission planning, regular family therapy, and treatment. COEs also encourage strong involvement from families and partners around discharge planning. In particular, COEs that treat adolescents commit to intensive family involvement during all stages of treatment whenever possible.

9) Collaboration with Payers

COEs recognize that eating disorders treatment centers cannot provide the high-quality care that patients so desperately need without building and maintaining positive relationships with insurance providers. COEs understand and respect payers' obligations to be fiscally responsible and efficient. At the same time, COEs maintain an unwavering focus on treating patients according to APA criteria and guidelines. COEs approach relationships with payers based on a belief that both providers and payers share a common goal of providing quality care to patients, and that they can work together in a mutually beneficial collaboration toward that goal. In developing treatment programs, COEs evaluate whether an expense is truly necessary and, most importantly, whether it will promote patient progress effectively and efficiently.

10) Education

The rapidly evolving eating disorders treatment industry is at a critical juncture in its history, with a pressing need for rigorous, peer-reviewed scholarship and research. COEs seek out opportunities to engage with academic institutions and other scholarly bodies to advance the field, integrate proven methodologies into treatment, and offer a setting in which to conduct academic research. COEs are also enthusiastic about offering education programs to health professionals and zealous in identifying other settings in which there is an opportunity to reach professionals in need of training in



eating disorders early identification, treatment, and referral. In the field of eating disorders, it is axiomatic that medical professionals outside the industry receive woefully little training related to eating disorders. The average physician only receives an estimated four hours of eating disorders training in his or her entire medical education. That is inadequate. Thus, COEs look for opportunities to educate health professionals about eating disorders — with the goal of saving lives.

To that end, COEs structure site visits as opportunities for education or legitimate marketing activities, not entertainment. The goal is to offer health professionals an opportunity 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. REDC has a written "Marketing Best Practices" document that includes a "no entertainment" policy outlining that its members are committed to making site visits educational. COEs have similar policies and procedures in place.

11) Advocacy

Any program that regards itself as a standard bearer in the eating disorders treatment industry is passionate about expanding access to care for every patient in need, regardless of socio-economic background. COEs are fearless advocates for patients in making sure that they can access all health insurance benefits due to them.

Leaders from inside the eating disorders treatment industry — as well as nonprofits and organizations working to support the field and eating disorders research and awareness — have been at the forefront of national and state advocacy efforts. Such efforts include a successful push for The Joint Commission and CARF to create national accreditation standards for eating disorders treatment programs. Advocacy efforts also resulted in the passage and signing in 2016 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 21st Century Cures Act includes measures to improve early identification of eating disorders by health professionals and to expand treatment coverage of eating disorders by explicitly clarifying that the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to eating disorders treatment, including residential. COEs are committed to conducting ongoing advocacy to ensure the dissemination of early-identification training and adherence to parity requirements.

Eating disorders treatment programs that aspire to be COEs are focused on moving the field ahead for the sake of patients by engaging in advocacy at the local, state, and national levels, both through individual efforts and by combining their voices with national trade and/or professional associations. In addition to legislative advocacy, COEs may make their voices heard by hosting educational workshops and seminars, sponsoring events, educating the public through mass media, and launching other outreach efforts.

With specific regard to media interviews and appearances, COEs embrace opportunities to participate in responsible and authoritative interviews aimed at educating audiences and raising awareness about these deadly disorders. COEs have a solemn responsibility to be good citizens in all forms of media in which they participate. COEs do not engage in practices such as releasing misleading photos of body size, showing "before-and-after" weights that are not representative of all patients with similar conditions, making unsupported claims about causation that are not evidence-based, speculating about the health condition of celebrities, or appearing on shows that exploit mentally ill patients in exchange for free treatment.

12) Technology and Data Systems

As technology evolves, COEs actively incorporate cutting-edge tools into both their business processes and the treatment and recovery process. Innovative technology can provide powerful methods to deliver care via telehealth, track data during and after treatment, involve and encourage patients in meeting treatment goals, and assist in the consistent, reliable collection of outcomes data that will move the field forward in establishing national performance benchmarks. As is the norm in health care, COEs are expected to implement state-of-the-art information technology platforms and electronic health records systems that are robust and HIPAA-compliant, focused on safeguarding patients'



protected health information and able to deliver real-time, consistent and reliable information sharing among all parties involved in the care and support of patients.

When telehealth eating disorder treatment services are deployed, COEs maintain the integrity of evidence-based treatment components when delivered via telehealth. Telehealth treatment models incorporate alternative data capture methods for clinically necessary physiologic and psychologic data elements, such as height, weight, vital signs, laboratory values, other medical testing results, and psychological and behavioral indices. COEs follow regulatory, state, and federal requirements and directives related to telehealth delivery and transparently communicate any availability and/or insurance coverage limitations of these services to potential patients, families, providers and other applicable parties.

Conclusion

Eating disorders are complex and lethal illnesses: An American dies roughly every hour as a direct result of one. Since its founding in 2011, REDC — a national professional association that represents approximately 80 percent of residential/inpatient eating disorders treatment programs in America — has set a high bar for quality and ethics in the industry. In addition to offering 24-hour care, all of REDC’s members also offer day treatment, and many offer intensive outpatient and outpatient treatment, underscoring REDC’s position as a key voice representing the entire spectrum of eating disorders care. REDC has used that platform to emphasize its core belief that those who provide care for vulnerable populations, including eating disorders patients, must pledge themselves to nothing short of the highest standards of conduct in both their clinical approach and their business practices.

In a short period of time, the field of eating disorders treatment has seen a surge in demand, rapid growth, additional investment in the marketplace, and an increase in scrutiny and calls for accountability. Most of all, the field itself has led the call for greater standards and accountability. Members of REDC are at the forefront of this charge.

REDC defines a COE as an organization that upholds the highest standards of clinical quality in eating disorders treatment. We believe that Centers of Excellence in the eating disorders field are recognized leaders in their field, defining best practices in both treatment and business operations and encouraging peers to adopt them; offering the gold standard in evidence-based care; utilizing a collaborative treatment approach that includes the patients themselves, their families, and their communities; advocating for reliable, consistent outcomes-data collection that will make it possible to evaluate eating disorders treatment programs based on national benchmarks; partnering with academic institutions to support research that provides actionable data to validate best practices in the field and incorporate new tools and techniques; maintaining programs that are well-capitalized to provide a stable presence in their communities; and remaining ever zealous about expanding access to care for every patient in need.

REDC members are expected to uphold the high standards outlined in this document and to work with other stakeholders to advance the field together. We applaud The Joint Commission and CARF for collaborating with the eating disorders treatment industry to help raise standards in eating disorders treatment, and we hope that this document provides these groups with additional expertise from practitioners on the front lines regarding standards that will continue to move the field forward for the benefit of patients. We also hope that this document is received as a clarion call for eating disorders treatment programs across the nation and the world to reaffirm their commitment to best-practice care — and to pledge themselves to the high calling of becoming or remaining an eating disorders Center of Excellence.