



ADVANCING INTEGRATED HEALTHCARE

Restrictive Eating Disorders ECHO[®]

Session 9: One Team, One Message

Date: May 16th, 2024

PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a project ECHO setting

Care Transformation Collaborative of RI

Welcome

- This session will be recorded for educational and quality improvement purposes
- Please do not provide any protected health information (PHI) during any ECHO session

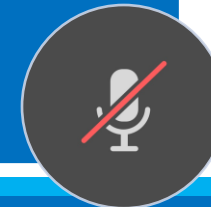
- Please turn on your video
- Please enter your name and organization in the chat box

Introduce Yourself



- Please mute your microphone when not speaking

Microphones



Agenda

Time	Topic	Presenter
7:30 – 7:35 AM	Welcome, Updates, & Case Presentation Schedule	Liz Cantor, PhD
7:35 AM – 8:00 AM	One Team, One Message	Christina Tortolani, PhD
8:00 – 8:10 AM	Case Presentation	Laura Dawson, MD Maureen McKenna, MD
8:10-8:25 AM	Discussion	
8:25 AM – 8:30 AM	Wrap Up, Next Meeting	Christina Tortolani, PhD Liz Cantor, PhD

Reminder

Thursday June 20th Session rescheduled to
Thursday June 6th 7:30-8:30 AM

Case Presentation Schedule

Session Title	Date	Presenter	Case Due
Session 9: One Team, One Message	May 16 th , 2024	Laura Dawson Maureen McKenna, Coastal Medical Toll Gate	May 1 st
Session 10: Harnessing Parental Anxiety	June 20th, 2024 June 6th, 2024	Colleen Vitale Atlantic Pediatrics	May 23 rd
Session 11: Navigating Challenging Family Dynamics	July 18 th , 2024	Laura Beaudry Bald Hill Pediatrics & Michelle Beller, Barrington Pediatric Associates	July 1 st
Session 12: Brain Recovery – Success Stories	August 15 th , 2024	Heather Pelletier & Brittany Vose	

CHRISTINA
TORTOLANI, PHD

One team, one message

Learning Objectives

- Describe importance of collaboration and communication among treatment team
- Identify 1 strategy around effective collaboration
- Identify 1 marker of ineffective collaboration

Team Based Care: *It Takes a Village*

- Primary medical doctor
- Therapist
- Psychiatrist (sometimes)
- Nutritionist (sometimes)
- Parents/ Caregivers
- Patient

The best outcomes for patients with eating disorders are associated with a collaborative approach by a interdisciplinary team.

As providers, we must talk to each other and to the families. A unified message is essential.



ED
treatment
is difficult
for
everyone
involved

There is often a high level of emotional distress and dysregulation, not only by the patient but also by the family and the providers.



The core principles of FBT should be the foundation for a strong multidisciplinary team.

Agnosticism, externalization, full nutrition first, and an expectation for full recovery are key elements to a highly functioning team.

The Imperative of collaboration

Bray, et al 2024, Levine 2017

A collaborative FBT team = working together is better

Creating and maintaining buy-in from team

The linchpin of teamwork is optimizing healthy communication

Systemic failures negatively affect team treatment, including burn out

Facilitators & Barriers for Buy in

- Creating buy-in from providers is paramount in building community care teams... WHY is this so difficult?
 - Poor understanding of eating disorders and treatment
 - Lack of interest
 - Limited time or institutional support
 - Burn out
 - Others?
- So then what enhances collaboration and buy in?
 - Psychoeducation, training, and relationship building
 - Others?

A collaborative FBT team

can share the burden and responsibility of patient care



build trust and respect



model effective communication to families



support for each other when treatment becomes difficult.

Optimizing Communication

Communication is essential in avoiding splitting or misunderstanding clinicians and in increasing support for patients and families.

Effective communication within a team can also serve to model what a united front should look like, which is a core principle in FBT.

5 signs of a *healthy* collaborative treatment team

There is clear and regular communication among the team members

There are clear and maintained boundaries

There are clear roles and consistency among providers

The team is willing and able to meet together and/or with you

There is a sense of unity and strength in the team

Communication gone awry...

There is a difference of clinical opinion and no clear way to address or resolve it

There are too many cooks

Biased care

Others?

The power of collaboration to prevent burnout

- A group of cohesive providers who see the benefit of creating community-based care teams can provide support for one another and prevent burnout and poor quality of care. (Levine, 2017)

In Sum

The use of multidisciplinary teams in a community can address critical gaps in eating disorder treatment, provide support to providers who may otherwise feel alone in providing eating disorder care, and enhance the efficacy of implementing eating disorder treatment.

Although it may be difficult to find and build teams within a community, it is worth investing the time and effort in making connections, training providers from multiple disciplines, and staying in frequent communication. This will ultimately give families the best opportunity to fight EDs.

Resources

- <https://www.gbwellness.com/post/how-to-recover-from-an-eating-disorder>
- <https://www.intechopen.com/chapters/53353>



ADVANCING INTEGRATED HEALTHCARE

Restrictive Eating Disorders ECHO® Case Presentation

Presenter(s): Laura Dawson, Maureen McKenna

Date: May 16, 2024

Contact Info: LDawson4@lifespan.org

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Care Transformation Collaborative of RI

Reasons for Selecting this Case

Do Not Include PHI

Why did you choose this case?	<p>Challenging case – patient new to practice, ED concern by report at first visit, no history/growth chart or rapport</p> <p>We don't offer FBT in the office but have access to community resources that are worth highlighting</p>
What questions do you have for the group?	<p>Methods for establishing rapport while making difficult and unwanted recommendations</p> <p>Strategies for engaging/aligning with a reluctant patient</p> <p>Ways to illustrate that a “healthy diet” has become unhealthy</p>

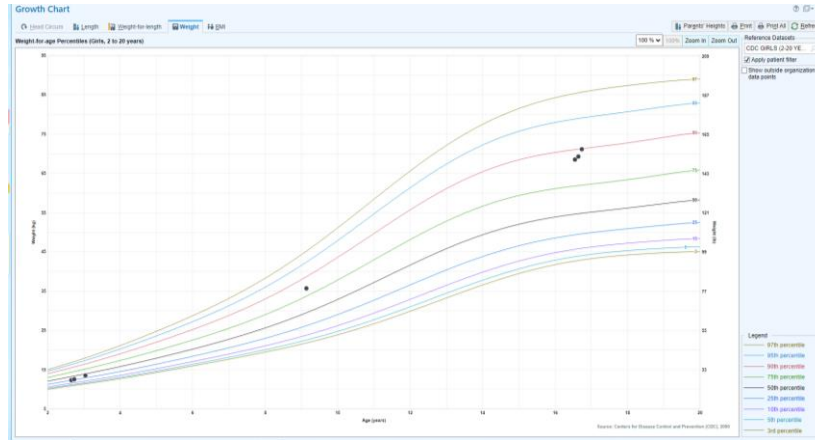
Basic Patient Information

Do Not Include PHI

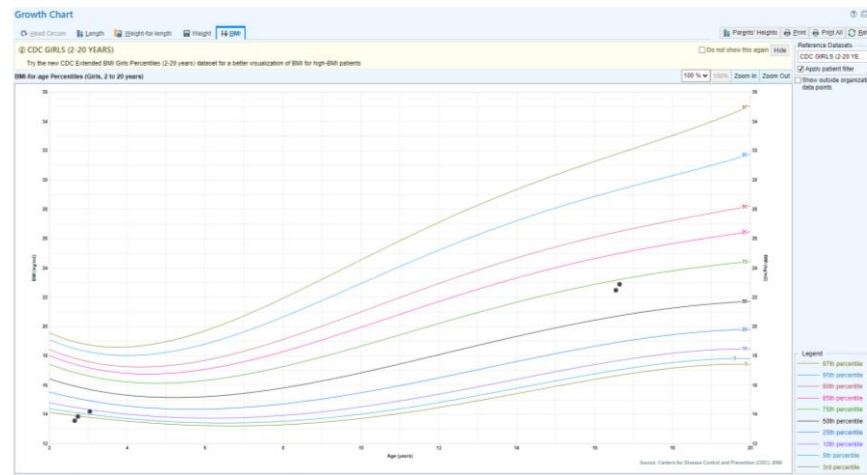
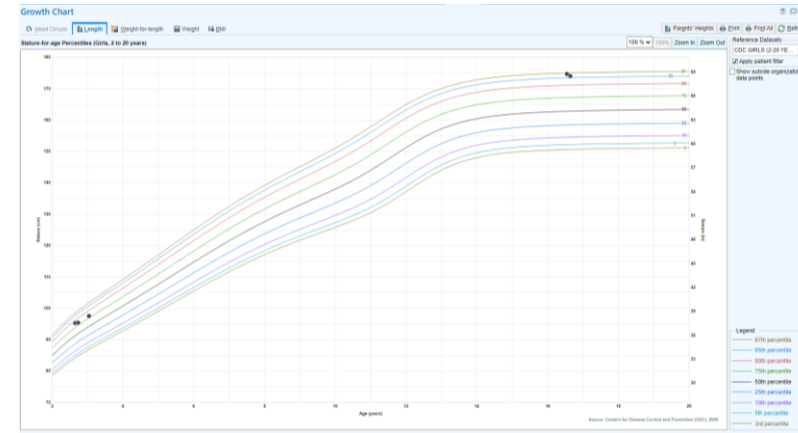
Age	16
Gender Identity	F
Race/Ethnicity	Not reported
Current Weight and Height	Weight: 157lb (90%) Height: 68.5" (96%)
BMI percentile and expected body weight	Current BMI 70% Highest weight 190lb = BMI of 94%
How long has the patient had concerning growth trends?	Since summer 2023 as reported by father
How long has this individual been in your care?	Since 2/2024
Insurance type (Commercial, Medicaid, Uninsured, Other)	BCBS

Do Not Include PHI

Weight for age



Stature for age



BMI

Does the Patient/Family have treatment goals?

Do Not Include PHI

- Father expresses the following goals for patient:
 - Weight restoration, at least partial
 - Improved diversity of diet, reduced restriction (especially carbs)
 - Ability to go out to eat
 - Improved social function
- Patient is content with current status

Do Not Include PHI

Relevant Background

Relevant medical and/or behavioral comorbidities	<p>Irregular menses</p> <p>Long-standing social isolation</p> <p>Sensory sensitivities</p> <p>Anxiety, depression and emotional regulation</p>
Relevant medications	MVI, Ca + vit D
Relevant lab results	Normal CBC, CMP, mag, phos, TSH
Relevant BH Screening results	PHQ-9 score: 3
Relevant SDOH Screening results	None
Family History of other psychiatric concerns	None

Relevant Social History

Do Not Include PHI

Family history of disorder eating?	None known
Family/patient history of trauma?	None known
School related concerns?	Honor role Hx IEP/504
Other social history concerns?	Isolation, long-standing Strained relationship with parents

Eating Disorder Treatment History

Do Not Include PHI

What interventions have been tried (e.g. re-feeding, meal supervision, exercise restriction)	Informal attempts by dad at persuasion
What treatment barriers have the family identified?	Patient's reluctance to change, mom's role is unclear
What levels of care have been used for treatment?	Single visit with nutritionist prior to our first office visit
What is the most recent course of treatment?	Integrative Family Therapy through Gateway, part of Project HOME
Other concerns with nutrition/eating (such as cultural considerations)?	Parental overweight and associated medical comorbidities

Physical Activity

Do Not Include PHI

Does the patient engage in regular physical activity? (yes/no) Please describe	Yes, lifting and cardio via online videos in her room
Other concerns with physical activity/exercise (such as physical restrictions, access, environmental safety)?	Unsupervised
What interventions have been tried?	None

Patient /Family Successes and Strengths?

Do Not Include PHI

- Successes
 - TBD
- Strengths
 - Follow through (office visits and recommendations), especially patient who is averse to treatment
 - Dad's recognition of disorder and desire to seek help
 - Family willingness to engage in therapy

Summary & Clarifying Questions



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CME Credits

(applied for MDs, PAs, Rx, RNs, NPs, PhD)

- BH clinicians can submit their certification to their accrediting agency for credit equivalency
- CME Credits – Please request session credits when filling out the evaluation at the end of the meeting.
- Evaluation/Credit Request Form: <https://www.surveymonkey.com/r/RSKN6W9>
- Evaluations must be completed to receive credit
- Certificates will be mailed ~ 1 month after event



Thank you!

Next Meeting:

Thursday June 6th, 2024 - 7:30 – 8:30 AM

Harnessing Parental Anxiety

Evaluation/Credit Request Form: <https://www.surveymonkey.com/r/RSKN6W9>