Supporting Document

Academy for Eating Disorders Proposal for a New Eating Disorder Topic

This request and documents were created by a task force of the Academy for Eating Disorders. Task force members are (in alphabetical order)

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The Agency for Healthcare Research and Quality (AHRQ) is charged with producing evidence to make health care

1. safer
2. improve quality of care
3. increase accessibility and
4. make health care equitable, and affordable

The vision for AHRQ's Evidence-based Practice Center (EPC) program is that all health care decisions are based on the best available evidence, resulting in the best possible health outcomes.

We believe that the AHRQ's mission is the appropriate agency to request a New Evidence Review from on the following topic:

"How does the current model of care delivery for eating disorders affect quality of care, equitable access to care (especially for publicly insured patients), and affordability of eating disorders treatment."

Background for a New Eating Disorder Topic

1. The last decade has seen a significant shift in the treatment landscape for patients with eating disorders. The field has seen a rapid rise in private for-profit programs providing residential and partial hospitalization levels of care. At the same time, a large number of university-based programs have been forced to reduce their beds or even close (provide numbers). This is worrisome as many patients with the most severe eating disorders are forced onto public insurance (Medicare or Medicaid) and eating disorder programs vary in their acceptance of these types of insurance. Historically, university-based programs were more likely to care for patients with public insurance than for-profit programs. Simultaneously, high deductible insurance products have become more and more of the norm, making even those with insurance effectively uninsured. **With the challenging insurance landscape intersecting with the shift in treatment offerings thus potentially impacting access, it is a key time to understand what treatments are delivered to individuals with eating disorders and who has access to those.** Importantly, these for-profit programs infrequently treat Medicaid or Medicare insured patients, who comprise a large percentage of severe and chronic eating disorder patients. Other populations are marginalized from care as well, such as underinsured patients in lower socioeconomic strata or in single-parent families who cannot travel distances for care, young children. This marginalization results in fewer than 15% of individuals with eating disorders successfully seeking and receiving any care at all.
2. **This change in delivery of eating disorder care also has led to uncertainty about the level of training that eating disorder professionals now receive** (e.g., milieu therapists or therapy aides versus psychologists for instance, which impacts quality of care).
3. **Outcome data are not shared, and it is difficult to gather information on the nature of treatment delivered and the extent to which it represents the evidence base or expected standards of care.** There is a lack of clinical equipoise in the eating disorder field in general, leading to further variation in care that diminishes the ability to assess comparative effectiveness between treatment models.
4. University-based programs have historically been the primary training centers for emerging medical and allied health professionals. **The disappearance of university- based programs drastically limits opportunities to train the next generation of healthcare professionals (psychiatrists, psychologists, dietitians, social workers, nurses, occupational, and physical therapists) who specialize in the treatment of eating disorders.** Although some for profit treatment centers are offering accredited training opportunities, these positions are limited in number and scope.
5. **Previous reports done by AHRQ already indicated that the literature regarding treatment efficacy and outcomes for anorexia nervosa, bulimia nervosa, and binge-eating disorder is of highly variable quality and the evidence base for the treatment of anorexia nervosa (especially in adults) is weak.** (Berkman ND, Bulik CM, Brownley KA, Lohr KN, Sedway JA, Rooks A, Gartlehner G. Management of Eating Disorders. Evidence Report/Technology Assessment No. 135.)

6. **A recent report derived from the Healthcare Cost and Utilization Project (HCUP) that includes the largest collection of longitudinal hospital care data in the United States showed that eating disorders have by far the highest mean cost per stay and mean length of stay when admitted to an inpatient unit** (Statistical Brief #249, https://hcup-us.ahrq.gov/reports/statbriefs/sb249-Mental-Substance-Use-Disorder- Hospital-Stays-2016.jsp). This calls for understanding who is receiving what type of care and whether the available resources are best utilized.
7. **Other reports indicate the patients with eating disorders are among the top 1% most expensive patients to insure** (JAMA Pediatr. 2015;169(10): e152682.doi: 10.1001/jamapediatrics.2015.2682. Personal communication Dr. Richmond). This supports the need to better understand treatment delivery and effectiveness.
8. Many patients do not have the resources to spend several thousand dollars a year until there is a crisis. **It is our impression that insurers are not financially prioritizing outpatient treatments; and these types of policies prevent patients and their families from seeking treatment.** The data on this observation is however not well established.

Summary

We view the eating disorders treatment field to be in crisis to the detriment of afflicted individuals and their families. It is our impression that the current landscape has led to inequitable access to care with only the most wealthy and insured patients having access to care in for-profit programs that may or may not deliver evidence-based interventions. Most importantly, our most severely ill patients who are covered by Medicaid and Medicare have increasingly fewer treatment options as university-based programs close under financial pressure. We propose that health outcomes in eating disorders, currently estimated to afflict 8.4% of women and 2.2% men are a topic worthy of AHRQ attention. As with other fields of medicine, there is a need to incorporate data-driven information to inform psychiatrists and psychotherapists about etiology and treatment, and establish standards for training and competency. Eating disorder treatment programs should be required to gather post-discharge outcome data on their patients to demonstrate effectiveness. This is rarely done at present (Friedman et al., 2016) and when performed, tends to measure outcome at discharge only, which does not show whether treatment results in lasting improvement.

We believe that it is essential to

1. **Gather data about access of underserved and publicly insured patients with eating disorders to adequate treatment and**

2. **Gather data on the state and development of training opportunities for physicians and psychologists in accredited training programs for internship, residency and postdoctoral training.**

This will help work with lawmakers and industry to direct better care to patients and promote better health outcomes.