**Improving Care Transition Between Inpatient and Outpatient Eating Disorders Treatment**

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2. **Why are you interested in participating in the Improvement Scholars Program?**

Relapse rates for individuals with eating disorders (EDs) requiring inpatient treatment are alarmingly high, with over 40% of those with anorexia nervosa readmitting to inpatient care (McFarlane et al., 2008). The sole qualitative study on this phenomenon highlighted problematic transition and post-discharge care experiences: patients report perceived lack of communication and/or continuity between the services and feeling that their inpatient discharge was premature and/or rushed (Bryan et al., 2022). Patients and families also reported that recovery was impacted by personally challenging aspects of the transition period, such as a lack of structure and support at home, increased responsibility for one's own well-being, and concerns about managing weight and food intake.

UNC's Center of Excellence for Eating Disorders (CEED) operates one of the few inpatient ED units in North Carolina and has heard similar concerns from patients and their families about the stepdown process from the Eating Disorders Unit (EDU) to lower levels of care. This is especially the case for patients who are underresourced (e.g., have no eating disorder treatment centers in their geographical area) or underinsured (their insurance only covers inpatient and outpatient levels of care). Patients in these categories are not able to follow the guidelines for recommended level of care at discharge (e.g., stepping down to a partial hospitalization program) and are at even higher risk for relapsing and requiring further inpatient treatment. The proposed project, which will focus on improving the transition between CEED's EDU and outpatient levels of care, has the potential to improve current treatment, increase the likelihood of patients' ED recovery, and reduce the individual, familial, and societal burdens of EDs. Specifically, by minimizing weight loss between inpatient discharge and initial outpatient appointment and thereby reducing the readmission rates to EDU, we anticipate a decrease in healthcare-related costs for families, a reduction in EDU's waitlist, and an expanded reach of effective care to more North Carolinians. Our interest in participating in the Improvement Scholars Program stems from the recognition of the need for guidance from clinical improvement experts to successfully implement and sustain this project, which has the potential to significantly improve care for individuals navigating the challenging transition from inpatient ED care. Furthermore, participating in the Improvement Scholars Program will position our team to continue spearheading and implementing additional quality improvement initiatives at CEED, fostering ongoing advancements in patient care.

3. **Which UNC Health improvement priority will your project address?**

This project will uniquely address several UNC Health improvement priorities:

*Health equity promotion:* Patients who are underresourced, underinsured, or who's family is Spanish speaking are more likely to have difficult transitions from inpatient treatment as they often have limited

treatment options. By improving this transition process for patients and their families, we hope to promote recovery for these individuals and improve health outcomes for these groups.

*Hospital length of stay reduction:* When patients have a difficult transition to outpatient treatment, they are more susceptible to hospital readmission. By improving the transition to outpatient care, we will increase EDU care access by reducing EDU readmission rate, while more efficiently improving patient outcomes and reducing healthcare costs post-EDU discharge.

*Outpatient care improvement:* One of the approaches for improving the transition between levels of care is improving parent and patient efficacy in adhering to discharge and treatment recommendations. In doing so, we believe that outpatient care can be more effective when symptom improvement is maintained between inpatient discharge and the first outpatient appointment.

4. **What is the problem or gap in quality you seek to improve?**

Improving ED treatment is essential to the health of North Carolinians. EDs are common; an estimated 9% of the U.S. population, including nearly 1 million North Carolinians, will have an ED in their lifetime (Deloitte Access Economics, 2020). EDs are associated with psychiatric and medical comorbidities and impaired quality of life. Among the deadliest of mental illnesses, EDs result in ~10,200 deaths nationally each year due to medical complications and suicide (Deloitte Access Economics, 2020). The financial impact of EDs in the U.S. is substantial, totaling nearly $400 billion in 2018-19, and exacerbated in recent years given the increase in EDs following the onset of the COVID-19 pandemic (Deloitte Access Economics, 2020). Further, the pandemic has led to an astonishing rise in ED treatment referrals, overwhelming the system and resulting in unacceptably long waiting lists (Hartman-Munick et al., 2022). Relative to individuals with other psychiatric disorders, patients with EDs are particularly prone to poor treatment response and premature treatment termination and often require multiple rounds of intensive, specialized treatment (Bryan et al., 2022). Some work has found that 40% of in-patient admissions required readmission, with 93% of these patients undergoing multiple hospital admissions within a short period (Bryan et al., 2022). More inpatient admissions contribute to longer illness duration, which is associated with poorer clinical outcomes and decreases access to specialty care. Patients have identified that the transition period between levels of care is a sensitive time as urges to resume eating disorder behaviors are strong and there is a high risk of relapse. Even when a patient is discharged home to caregivers, these caregivers often do not feel efficacious in managing eating disorder urges and behaviors. By improving discharge planning while patients are on an inpatient unit and providing resources during the transition period, we hope to improve treatment outcomes for patients, particularly for those who will be stepping down directly to an outpatient level of care (rather than a partial hospitalization or intensive outpatient program, where there is inherently more structure).

5. **Describe the patient population affected, scope, and impact of the problem**

*a. What is the specific patient population your project will impact?*

EDs do not discriminate. Contrary to the commonly held belief that EDs predominately impact young, White females, research indicates that Black, Indigenous and people of color are affected by EDs at similar rates as their White, Non-Hispanic peers (Cheng et al., 2019). Of concern, there is evidence of a significant treatment gap: compared with privately insured patients, only 33% of patients with public insurance receive the recommended mental health treatment for their ED (Moreno et al., 2023).

UNC's CEED provides inpatient and outpatient care to hundreds of patients each year. Because CEED is the *only* inpatient ED unit in North Carolina accessible to patients with government insurance, CEED serves a racial, ethnic, and socio-economically diverse patient population. CEED is also one of few treatment centers employing a Spanish-speaking ED provider who is able to provide culturally appropriate treatment for patients and families from the Latino community.

*b. How many patients are in the population?*

UNC's Eating Disorders Unit (EDU) is a 6-bed unit that has, on average, 58 admissions per year. The average length of stay on EDU is 24 days.

*c. How frequently does the problem occur?*

Since COVID restrictions were lifted (Jan 2022), 50% of EDU patients have stepped down into CEED outpatient services (13 of 30 in 2022, and 25 of 48 in 2023).

*d. What is the impact of the problem?*

The lack of a smooth transition to lower levels of care can increase the risk of relapse, which may lead to patient readmission to higher levels of care. Even for those who remain at the outpatient level, the duration of their illness may be extended, and longer treatment may be required (Vall & Wade, 2015).

6. **What do you think are the underlying causes of the problem? Why do you think the problem is happening?**

Several factors impact patient outcomes during the transition period. First, discharges may occur before a patient is clinically ready to leave the current level of care due to insurance not covering additional days in inpatient care or due to patient extenuating circumstances. Even if patients are medically stable, they are at increased risk for engaging in eating disorder behaviors during the transition period due to many factors including increased body dissatisfaction from weight gain, inadequate distress tolerance and other coping skills, or poor skill with personal meal planning (Vall & Wade, 2015). Unexpected discharges also make it difficult for all team members to meet with the patients to provide resources and other information before they leave the inpatient unit. Finally, the time gap between the last day of inpatient care and the first day at the next level of care can be several days or even weeks. This can be a challenging time for patients if they do not feel prepared or have the necessary resources to abstain from eating disorder behaviors.

For adolescent patients, the primary treatment modality used on EDU and at CEED is Family Based Treatment (FBT). FBT requires that parents take full control of meal planning, preparation, and serving, and an important predictor of recovery among children and adolescents is parental comfort and self-efficacy with implementing FBT (Gorrell et al., 2023). Parents have reported to CEED providers that they felt underprepared for adhering to FBT when their children are discharged from EDU, which could be contributing to higher rates of relapse and readmissions. Additionally, while EDU providers educate families on commonalities of ED recovery (i.e., that EDs are often chronic, long-term illnesses unlikely to "be fixed" in a linear or timely fashion), the lack of comprehensive support given to families in the step-down process can leave caregivers feeling unprepared for the time and effort ED treatment will require post-discharge. Unrealistic expectations of outpatient treatment can result in increased parental distress during the step down and outpatient treatment process and contribute to poor patient outcomes.

While relapse and hospital readmission among patients with severe EDs is not uncommon, these setbacks can be extremely frustrating and upsetting for both patients and families. Putting measures in place, such as increasing support during the stepdown process, could mitigate relapse and readmission and promote patient and family self-efficacy in the recovery process.

7. **What is the history of improvement or attempted improvement at UNC Health? What work will your proposed improvement build on?**

Until 2017, CEED had an ED partial hospitalization program (PHP) that served as a transition for many patients after their discharge from inpatient treatment on EDU. Although this program was more in line with guidelines for ED treatment that recommend gradual re-entry into daily life, UNC's ED PHP was discontinued due to budget and resource constraints.

The proposed improvement project seeks to address the resultant care gap created by the absence of the PHP program. While the ideal scenario would be for all patients to have the option to step down to PHP, this is not a viable option for many EDU patients who are covered by public insurance and therefore do not have access to any PHPs in the region. By improving the transition process from inpatient to outpatient treatment, we aim to provide more comprehensive and accessible support for patients seen on EDU who do not have access to an intermediate level of care.

Over the past year, our team has taken additional steps to improve the discharge process. A social work intern (Madeline Frank) collaborated with the EDU Case Manager to enhance the quality of information shared with families in the week before hospital discharge. Additionally, one of the current postdoctoral fellows (Savannah Erwin) has developed a multifamily skills group curriculum to provide psychoeducation on EDs and their treatment and to provide an opportunity for caregivers' skill-building. The Improvement Scholars Program would provide dedicated resources to more comprehensively improve the transition process and a help us to establish a structured framework to assess the impact of these and future quality improvement initiatives.

8. **Please complete the "Measures Table". Please describe the anticipated outcome measure(s), 2-3 process measures, and one balancing measure. Please do not include more than 5 measures total.**

| Measure Name | Measure Type | Measure Calculation | Measure Exclusion | Data Source | Baseline | Goal | Collection Frequency |
|---|---|---|---|---|---|---|---|
| Average change in %EBW[1] | Outcome | Numerator: change in %EBW discharge to initial outpatient appointment Denominator: #patients | Patients who are expected to lose weight post-discharge from EDU | Patient Chart | TBD (will collect prior to Oct 2024) | 0% | At EDU discharge, at initial CEED appointment |
| Parent Versus ED Scale[2] | Process | Total Score | | Survey | TBD (will collect prior to Oct 2024) | Increase | At admission to EDU<br>At discharge from EDU<br>At initial CEED appointment<br>1 month into outpatient |
| Meal plan compliance | Process | Weekly % meal plan completion | | Nurse report on EDU, CEED RD determination based on parent/patient report | TBD (will collect prior to Oct 2024) | 100% | Daily on EDU, at initial CEED RD appointment |
| EDE-Q[3] | Process | Total Score, scaled scores | | Survey | TBD (will collect prior to Oct 2024) | Decrease (total score) | At admission to EDU<br>At discharge from EDU<br>At initial CEED appointment<br>1 month into outpatient |
| Provider burden | Balancing | Total Score | | Survey | TBD (will collect prior to Oct 2024) | No change in provider burden | Quarterly |

[1]*%EBW: Percent of expected body weight; calculated based on individual patient's historical BMI for age, based on growth charts*
[2] *Parent Versus ED Scale: a 7-item questionnaire adapted from the Parent Versus Anorexia scale, that measures parent self-efficacy (Rhodes et al., 2005)*
[3]*EDE-Q: Eating Disorders Examination – Questionnaire; a 28-item self-report questionnaire that measures eating disorder symptoms*

9. **What ideas do you have for changes that will result in improvement (your improvement strategy)?**

We have an overall goal of improving transition from inpatient to outpatient (EDU to CEED) with a SMART goal of decreasing weight loss between inpatient discharge and initial outpatient visit. Our improvement strategy includes changes to the frequency, quality, and modality of information communicated with patients and families about managing an ED after discharge from inpatient care.

*Changes to EDU Process*

We will introduce a **readiness for discharge checklist** for patients on EDU to be able to track a patient's progress in treatment. The checklist will include measures of weight restoration (%EBW), medical stability (vitals), and ED behaviors (% meal plan completion) as well as conversations and skills that need to be reviewed with EDU patients and their caregivers prior to discharge (e.g., home menu plan, meal support skills). Although there are many discipline-specific components of discharging a patient, there is not a current systematic protocol in place to ensure patients and families have been adequately prepared for discharge from EDU. This checklist will be displayed in the patient's Epic chart so that all providers are aware of the progress and can collaborate in completing the necessary components. Having this checklist in the patient's chart can facilitate clearer communication with the outpatient team about the patient's progress during their inpatient stay.

We also propose adding a **planned discharge preparation meeting** with key providers (e.g., RD, SW), the patient, and their caregiver(s) during the week of discharge to review discharge and home care plans. Home menu plans are a critical component of outpatient ED treatment, and patients and their caregivers must understand and plan for how to meet the patient's nutritional needs to prevent relapse, particularly in the time between discharge and their first outpatient appointment. Having a scheduled meeting with the patient's treatment team can offer a structured opportunity to review expectations and answer questions.

*Transition Touchpoint*

We will ask patients and caregiver(s) to complete a **brief check-in** between the patient's discharge from EDU and their initial outpatient appointment. A digital survey asking for self-report of menu compliance will prompt patients (or caregivers, for patients set up to receive FBT) to reflect on their progress since discharge.

*Additional Family Support*

A weekly **multi-family skills group** for caregivers of patients on EDU and caregivers of patients receiving care via CEED led by psychologists will provide psychoeducation on the nature and treatment of EDs. Much of the group material will reinforce information that is conveyed to patients on EDU and in other levels of care. Because EDU is primarily resourced for medically stabilizing and weight restoring the admitted patient in addition to limitations imposed by The Joint Commission, it is not feasible to involve caregivers in much of the treatment process on the unit. However, in the treatment of EDs, caregivers play a crucial role in managing at-home care (e.g., planning, prepping, and plating meals and providing meal support). This group will offer families much needed support in navigating ED treatment across levels of care. A culturally sensitive version of the multi-family group will be conducted in Spanish for families from the Latino community.

10. **How has this problem has been addressed successfully elsewhere?**

Due to the limited scope of research and the privatized nature of many treatment centers which seldom publish research findings, there is limited data on effective post-discharge care strategies and

transition support for EDs. In terms of the existing literature, a systematic review focusing on transition support interventions in the setting of inpatient care examined 14 studies (Bryan et al., 2021), the majority of which implemented psychological interventions delivered towards the end of the inpatient stay or after discharge, similar to what we are proposing. Experienced Caregivers Helping Others (ECHO) and family therapy were two interventions targeting caregivers. ECHO is a guided self-help skills training intervention, consisting of a book and coaching sessions, designed to support caregivers support loved ones with EDs (Hibbs et al., 2015).

Additionally, an ED treatment center in the Netherlands developed a relapse prevention guideline for adolescents and adults with anorexia nervosa. The guideline proposes a theoretical framework for relapse prevention, a manual for professionals, and a workbook for patients. Central to its approach is the creation of a relapse prevention plan (RPP). The RPP is developed by the patient in collaboration with health care professionals and family members, aiming to identify early signs of relapse so that prompt actions can be taken to respond effectively. These existing materials will be reviewed to inform the resources shared with patients and families on EDU.

11. **How will Carolina Quality tools (Just Culture, SAFE reporting, team communication and teaming skills, huddles, and visual management boards) be used to support the work? Although use of these tools is not required, applications including them will be strengthened.**

Our project will be supported by *Briefs* and the *Shared Mental Model* from the TeamSTEPPS toolkit.

*Briefs:* We have been meeting weekly as an interdisciplinary team to discuss quality improvement. Each meeting has an agenda (checklist) and participants review responsibilities, expectations, resources, and questions. At the end of each meeting, we review roles, expectations, and make an agenda for the next meeting. This template will be used for all project meetings, both Core Team meetings and meetings with Ancillary Team Members.

*Shared Mental Model:* in the initial interdisciplinary meetings, we first took time to map out treatment goals before coming to a consensus on treatment priorities and establishing goals for quality improvement. We will continue to meet regularly to reestablish this shared mental model with all members of our project team.

12. **Please describe how your project addresses one or more of the 5 elements reflected in the Quintuple Aim for Health Care Improvement.**

The project can improve health care for patients by targeting improvement in the transition between ED levels of care, to prevent relapse and allow for continued patient gains in physical and mental wellbeing. Our project will do so by enhancing the patient's discharge planning across disciplines and providing patients and caregivers with the necessary resources to maintain gains during the care transition. This intervention will be especially important for the patients who are under-resourced due to their insurance and only have an outpatient level of care available to them. Finally, by making the transition process and period more successful, we hope this will reduce the likelihood of patients needing to be readmitted to a higher level of care, overall reducing financial cost, as well as the individual and familial illness burden.

13. **Please describe the support and engagement you have from leadership for the work you are proposing. Please indicate leaders with whom you have consulted about this proposal.**

This project has been discussed with the EDU leadership team, which is comprised of providers from multiple disciplines who are enthusiastic to improve this challenging aspect of care. Jean Doak, PhD and Mae Lynn Reyes-Rodriguez, PhD represent the psychology leadership on EDU and have been involved in all aspects of developing this project. Tonya Foreman, MD is the attending psychiatrist on EDU and she has been informed of this project and has provided feedback and encouragement. Rebecca Crane is the nurse manager on EDU and she was consulted when developing this proposal. We have had other members of the interdisciplinary team participate in working groups discussing how to improve transitions, including social work students, medical students, a dietician, and nursing.

**14. Who will comprise the project team?**

*Team Leads:*

The Team Leads will be responsible for overseeing day-to-day tasks and data collection. Both Savannah and Shelby are current postdoctoral fellows with experience conducting research and providing clinical services in several different inpatient and outpatient care settings. Team Leads are:

- Savannah Erwin, PhD
- Shelby Ortiz, PhD

*Project Sponsors:*

Project Sponsors have executive authority over CEED's inpatient and outpatient services. Our Sponsors will be regularly apprised of the team's progress and can advise and facilitate strategic collaboration with other senior leadership. Project Sponsors include:

- Rebecca Crane, MSN, RN, 5NS Nurse Manager
- Jean Doak, PhD, CEED Clinical Director
- Mae Lynn Reyes-Rodriguez, PhD, Director of UNC EDU Psychology Services
- Tonya Foreman, MD, Attending Psychiatrist of UNC Eating Disorders Unit

*Core Team:*

The Core Team will meet weekly to review project PDSAs. This team has already been meeting regularly for the past six months to develop and implement a data collection process which will allow us to further assess areas for quality improvement within CEED. Core Team members include:

- Mae Lynn Reyes-Rodriguez, PhD
  - In addition to her role as a Sponsor, Dr. Reyes-Rodriguez has been and will continue to be a member of the Core Team. Dr. Reyes-Rodriguez brings clinical and research expertise to the team, with a particular focus on ensuring our care is culturally appropriate for the range of patients we serve.
- Jean Doak, PhD
  - As CEED's Clinical Director, Dr. Doak is both a Sponsor and a Core Team member. Dr. Doak will serve as a content expert in step-down care and a bridge between our project team and the Department of Psychiatry.
- Camden Matherne, PhD
  - Dr. Matherne is a licensed psychologist and faculty member at CEED in the Department of Psychiatry within UNC's School of Medicine. Dr. Matherne brings expertise in clinical care and research across levels of care and has and will continue to provide invaluable mentorship to Drs. Erwin and Ortiz.
- Isabel Rodriguez, MPH, RD
  - Isabel is a medical student at UNC and was previously the dietician on EDU. From her role on EDU, Isabel has experience in providing psychoeducation on nutrition and menu planning to patients and their families and supporting them in the transition between levels of care.
- Madeline Frank, BA
  - Madeline is an MSW/MPH Candidate at UNC. As an intern with EDU's Case Management team, Madeline coordinated transition of care for patients discharging from EDU. Additionally, for the past several months she has been working with the Core Team members to establish a data collection process across CEED's inpatient and outpatient services which will be essential infrastructure for this and future QI projects.

*Ancillary Team:*

Ancillary Team Members will participate in regular meetings to discuss progress, facilitate interdisciplinary collaboration, problem-solve difficulties, and liaise with other members of their discipline to meet project goals. This team has been meeting regularly over the past six months to enhance interdisciplinary care delivery for our eating disorder patients and will continue to support this QI project. Ancillary Team members include:

- Nursing management representative (Rebecca Crane, or Tamara Ascher, Luke Lavecchia)
- EDU floor staff representative (Laura Barcenas, Joan Shannon, Debbie Murphy, or Krista Maddock)
- Clinical Care/Case Management representative (Carrie Sioberg, MSW, LCSW, MBA or intern)
- Psychiatry representative (Tonya Foreman, MD or rotating resident)
- EDU intake counselor (Rosalind Roberts)
- Psychology representative (Mae Lynn Reyes-Rodriguez, Jean Doak, Camden Matherne or postdoctoral fellow)
- Dietician representative (Leah Grace Hamilton, MS, RD, LDN or Sarah Faigle, RD)

**15. How will you ensure sufficient time to dedicate to the project over the scholar year? Although time commitment to the program varies throughout the year, Scholars may expect to spend at least 2 hours per week (with range from 1 hour minimum to 5 or more hours a week) on project-related activities.**

Time has already been built into our schedules to work on these priorities (e.g., weekly team meetings on Wednesday and Friday mornings). Supervisor approval has been given to the Team Leads to dedicate 2-5 hrs/week to this project. We have a large team invested in making programming changes and will have members from multiple disciplines that can attend work group and IHQI program meetings.

**16. What factors do you anticipate will foster and hinder improvement?**

*Factors that will foster improvement:*

CEED's patient care teams, both on EDU and in the outpatient clinic, are dedicated to providing the highest quality of care and to comprehensively supporting patients. Many team members also recognize that improvement is essential for some of our processes, especially in the transition period from an inpatient to outpatient level of care. Our team has demonstrated a commitment to quality improvement through high attendance rates across disciplines in weekly "EDU Programming Improvement" workgroup meetings over the last 6 months. Given both the commitment of team members to supporting patients, and recognition that an enhanced process for the transition from EDU to CEED could have the potential to reduce readmission rates, we are confident that this improvement project will have excellent support from key stakeholders.

Additionally, EDU has a demonstrated history of overcoming barriers to quality improvement. For example, within the last year we began holding weekly patient-centered team rounds, where patients are invited to discuss their care and treatment plan with the whole interdisciplinary team, as a means of empowering patients as agents of change in their treatment. While this was initially challenging to implement and is significantly more time intensive than meeting without patients, the team has engaged collaboratively with each other and with patients to improve patient-centered rounds as areas for growth have been identified.

*Factors that may hinder improvement:*

While there is no doubt of staff and provider commitment to supporting patients, significant constraints on the numbers and time availability of personnel may act as a barrier to improvement. For example, the EDU Case Manager splits her time with the child/adolescent psychiatry unit, the EDU psychiatrist is not full-time, and our nursing pool is shared with the child/adolescent psychiatry unit. Thus, interdisciplinary schedule coordination may be an initial challenge to overcome. Additionally, while EDU serves a diverse patient population, we have very few staff members who are able to communicate with patients and families in languages other than English. While we can, and do, use translators to ensure that that all patients and families have appropriate language access, it may be a challenge to alter our processes for patient transition to CEED in a manner that ensures equal language accessibility. While we will not be able to address all languages, we will adapt our materials for Spanish-speaking patients, who comprise the majority of our non-English speaking patients on EDU.

**17. What ideas do you have for sustaining the improvement at the end of the Improvement Scholars Program?**

After receiving expert feedback on how to analyze and interpret data to assess the effectiveness of current initiatives and identify additional programming changes, we hope to embed these procedures within our treatment standard of care. Specifically, we will continue to analyze data on a quarterly basis to identify additional areas for improvement with patient care within CEED. The findings from this project will be used to support subsequent grant funding to address additional care limitations.

**18. Implementation Timeline**

| Prior to Start Date | October-December 2024 | January-July 2025 | July-September 2025 | September 2025 and beyond |
|---|---|---|---|---|
| Obtain IRB approval; implement data collection process across levels of care | Receive IHQI expert feedback on implementation plan for improving transition processes; collect pre-implementation data | Provide education and rationale to providers on upcoming service changes; implement changes within EDU's treatment procedures; data collection is ongoing | Evaluate the feasibility, acceptability, and effectiveness of the program through patient and provider feedback | Continue to improve intervention; Present findings to IHQI; identify other interventions to implement |

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