*SCAN Advanced Practice Guide*

Sports, Cardiovascular, and Wellness Nutrition
a dietetic practice group of the Academy of Nutrition and Dietetics

# Transitioning Care Effectively

## A Guide for the Expert Level Registered Dietitian Nutritionist (RDN) Working with Clients with Eating Disorders

*It is well known in the disordered eating field that transitioning between levels of care can be difficult. Outpatient RDNs play a major role in the client's transition to and from higher levels of care. Presented here are guidelines and suggestions for facilitating these transitions with the goal of providing optimal care and improving treatment outcomes.*

*Depending on the treatment team, some tasks may be carried out by other team members. These guidelines were created for RDNs with expert level of training and experience as defined by the Academy of Nutrition and Dietetics. An expert practitioner is an RD who is recognized within the profession and has mastered the highest degree of skill in or knowledge of a certain focus or generalized area of dietetics through additional knowledge, experience, and/or training. An expert practitioner exhibits a set of characteristics that include leadership and vision and demonstrates effectiveness in planning, achieving, evaluating, and communicating targeted outcomes. An expert practitioner may have an expanded or specialist role or both, and may possess an advanced credential, if available, in a focus area of practice. Generally, the practice is more complex, and the practitioner has a high degree of professional autonomy and responsibility[1] RDNs with this level of expertise may therefore be involved in helping individuals or institutions navigate critical pathways in the health care system, creating policies and procedures for individuals and institutions and ensuring that best practice guidelines are met.*

*While these guidelines, which are supported by the literature,[2-4] were developed primarily for transitions to and from residential care, many are also appropriate for transitions relating to intensive outpatient programs. Use your professional judgment and reach out to experienced disordered eating professionals for support and supervision when needed.*

## TRANSITIONING TO A HIGHER LEVEL OF CARE

***When a client goes from outpatient care to a higher level of care:***

- Collaborate and communicate with other team members when making recommendations and decisions to ensure that everyone is in agreement.
- Educate the client/family about best practices and treatment options. Coach them on choosing a quality program that matches their values, beliefs, and philosophy.
- Help the client/family prepare for transition by explaining what to expect during treatment and discussing the challenges of returning to a less structured environment after discharge. Describe the differences they can expect between residential, intensive outpatient, and outpatient settings in terms of degree of structure and monitoring. Work with the facility prior to discharge to create an outpatient structure necessary for continued patient improvement (which differs among patients).
- Obtain a signed consent from the client/family before communicating with the facility. Tell the client that you will communicate with the facility, and follow up with the client after treatment is completed.
- Prior to or at time of admission, contact the facility to share information about the client (this may be with the case manager, therapist, and/or dietitian). Discuss observations, assessment, nutrition

diagnosis, weight target recommendations, nutrition goals, and interventions to date. Share growth charts, if available. Make sure everyone is in agreement

- Explaining that treatment appointments will become less frequent as the client progresses toward all defined goals, *not* just a weight goal.

***Additional information for RDNs working in a university setting:***

Early in a student's treatment, determine the level of parental involvement that is appropriate. If appropriate, the norm is to obtain signed consent allowing communication with the student's parent(s) that will continue when the student is discharged from a higher level of care and returns to the institution.

Obtain consent from the student to communicate with the Dean of Students office.

Notify case management and/or the Dean of Students office and work collaboratively with them to ensure that all parties are aware of the situation and agree with the plan.

Collaborate with the treatment team to determine the criteria that must be met for the student to return to the institution.

Familiarize yourself with the institution's medical leave policies and discuss pertinent parts with the student.

Ensure that appropriate documents have been completed and submitted, and make sure you have a photocopy

Obtain signed consent to communicate with the facility; this may be done by the counseling office or the medical provider, rather than by the dietitian.

## TRANSITIONING FROM A HIGHER LEVEL OF CARE

***When a client returns to outpatient care from a higher level of care:***

about goals (who is setting them and why), involvement of family, and specifics such as target weight ranges.

Ask your contact at the facility if he/she would be willing to support the client's outpatient recovery by doing the following during treatment:

- Emphasizing throughout treatment and upon discharge the importance of continuing weekly treatment at the outpatient level to ensure that progress toward recovery continues.
- Explaining that visit frequency will be determined by outpatient practitioners and that adhering to the recommendations should be a high priority, above other activities in the client's schedule.

If you have not heard from the facility prior to the client's first appointment, contact them to obtain a discharge summary and/or treatment plan including the following (obtain as much information as you feel you need to provide good continuity of care):

- Medical diagnosis code(s), including comorbidities, to be used for billing purposes.
- A list of treatment team members, their contact information, and scheduled initial appointments. In addition to having an RDN on the team, it is recommended that the treatment team consist of a primary care provider (MD, PA, ND, or NP); therapist/counselor; family, care providers, and/or friends; and possibly a psychiatrist, family therapist/counselor, and/or other specialists.
- Admission and discharge weights.

The emphasis on weight is often too high without enough emphasis on behavior change.

- Helping the client clearly understand discharge recommendations, including goals related to weight, health, exercise, and behavioral maintenance to prevent relapse.

Request periodic status reports (frequency depends on the client's situation) and determine the preferred method of communication. Be sure that method of communication complies with privacy laws.

Request communication about the timing of the client's discharge, and request a prompt discharge summary.



- Target weight range recommendations.
- Discharge eating plan, calorie goals, and any other nutrition recommendations. It may be helpful to obtain information about items that are unique to the facility (e.g., exchange lists).
- Exercise or physical activity limitations and goals.

- Recovery goals as discussed with the client.
- Eating thoughts and/or behaviors that need to be monitored.
- Knowledge, ability, and competency level of client as well as activities in which the client participated.
- Knowledge, ability, and expectations of family, care providers, and/or friends in supporting client's recovery.
- Discharge medications, supplements, and any nutrition- or weight-related side effects that have been observed or are anticipated.
- Recommendations from the facility regarding priorities for next steps (e.g., involvement of family/friends; books/references to start or build upon; food challenges and food fears).

Have the client and parent/guardian, if needed, sign consent forms at the initial appointment.

Help the client develop a transition plan.

- Remind the client and family about the realities of treatment and the challenges of returning to a less-structured environment.
- Discuss what was most helpful during treatment and how to replicate that in an outpatient setting. Also, discuss what was not helpful.
- Discuss what was accomplished at the facility, including food challenges. Ask about and clarify nutrition-/food-related language used at the facility (e.g., exchanges, calories, desserts).
- Help the client manage energy needs as exercise is initiated or increased; expand food choices and flexibility; and figure out how to settle into his/her natural weight by understanding how the body works to maintain weight.
- Advocate for the role of family members (parents, spouse) and/or close friends in supporting recovery. Examples include grocery shopping, meal planning, food preparation, serving portions, checking portions, and supervision during or after eating.
- If family-based treatment (FBT) has been recommended by the treatment facility, share research about it and the RDN's role in helping parents appropriately support recovery in the outpatient setting. It is important to note that with FBT, parental control will begin upon discharge from inpatient therapy and then will gradually be transitioned back to the client as appropriate; this can be a difficult transition, if during inpatient treatment the client is making most of the nutrition choices. Ask the treatment facility if they are preparing the family with education and therapy so they can implement FBT upon discharge.
- If the client is a college student and there are dietitians at the college who are skilled in eating disorder treatment, explore the possibility of transferring care to one of these practitioners. Having both a school and home dietitian simultaneously is strongly discouraged.
  However, having RDNs in both locations may be beneficial during summer break. The key point is that treatment needs to be consistent over time.
- Help the client anticipate lapses and create a plan for dealing with them.

Determine how the treatment team will coordinate care and how often communication needs to occur.

Determine whether family/friends need to be informed or educated about the client's process of treatment, and determine who will provide that.

Collaborate with the team and the client/parents to establish goals and expectations. This may be in the form of a contract and could include (but is not limited to) weight goals, physical activity parameters, medical parameters such as blood pressure and heart rate, eating disorder behaviors, and indicators of the need to return to a higher level of care or make other changes to the treatment plan.

Determine the frequency of outpatient visits. Upon discharge from an inpatient facility, follow recommendations from the facility regarding follow-up care. As health improves, appointment frequency is adjusted as determined by the providers (*not* by the client's convenience). Advocate for best practices with team members as needed and appropriate, especially for care providers who are not highly informed about disordered eating. If needed, request that the treatment facility provide detailed information directly to care providers regarding recommendations for outpatient follow-up.

- It is helpful to families and individuals for the treatment facility as well as the

outpatient team to look into insurance coverage, especially for outpatient services.

- Depending on the client, it may be useful to follow up with the treatment facility a few weeks after discharge to evaluate and discuss how the transition is going.
- In communities with limited access to skilled eating disorders practitioners, the RDN can be a valuable resource for advocating best practices. Request that the facility provide written information outlining the types and frequency of medical monitoring recommended post-discharge. For physicians' guidelines, use the Academy for Eating Disorders Report: Eating Disorders: Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders.[5]

***Additional information for RDNs working in a university setting:***

- Ensure that the student succeeded in following through with the treatment recommendations while on leave and meets criteria for returning to the institution.
- Know that some institutions do not have the resources for providing the frequency of visits recommended in this guide. It may be necessary to collaborate with community dietitians and therapists.
- Ensure that all members of the team including case management and/or the Dean of Students office are aware of the treatment goals and progress made.
- Help the student identify and make connections with recovery support resources on campus. Examples include eating disorders recovery support groups, RDNs who can help the client navigate food service options, and multidisciplinary teams of professionals that can support students with disordered eating.
- Help the student create a plan for protecting recovery while away from school (e.g., during vacations, semesters abroad).



## ACKNOWLEDGMENTS

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## REFERENCES

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2. American Dietetic Association: standards of practice and standards of professional performance for registered dietitians (competent, proficient, and expert) in disordered eating and eating disorders (DE and ED). *J Am Diet Assoc.* 2011; 111:1242-1249 e37.

3. American Dietetic Association: Position of the American Dietetic Association: nutrition intervention in the treatment of eating disorders. 2011;111:1236-1241.

4. Academy for Eating Disorders. AED Report 2012,second edition: Eating Disorders: Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders. Available at www.aedweb.org.

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## ADDITIONAL RESOURCE

"Inpatient is from Mars, Outpatient is from Venus: Bridging the Gap in Eating Disorder Treatment." Webinar by Jessica Setnick and Dena Cabrera. Available at www.vimeo.com (webinar 70974388).