



How to Set up and Run a Virtual Eating Disorder Practice

Treating the Digital Patient During the COVID-19 Epidemic

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Agenda

1. Why Are We Here?
2. Telemental Health Primer
3. Regulatory and Ethical Questions
4. Leveraging Mobile Health
5. Recovery Record Demo
6. Case Study
7. Question and Answer



Telehealth Primer

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A REVIEW OF THE LITERATURE

- Acceptability has been overall high.
- Preference for the modality impacts effect.
- Drop-out rates remain concerning.
- High utility for early intervention and secondary prevention.
- Challenges remain with diagnostic process.
- Uncertainty in field about how to blend care.
- Use in relapse prevention is very promising.
- Stepped-care continuum may be cost-effective.

(Aardoom et al., 2016; Gulec, 2011; Fichter, 2011; Kass et al., 2016, Watson, et al., 2016)

WHERE DOES PSYCHOTHERAPY TAKE PLACE?

- Healthcare in the United States takes place at the location of the **client** (originating site)





BENEFITS OF TELEBEHAVIORAL HEALTH

Clients tend to have less inhibition online

Clients may be more willing to reveal traumatic events

The clinician may see the client's living/work space

Shy clients often become interactive

Clients have a greater sense of control

- There are fewer travel and time constraints

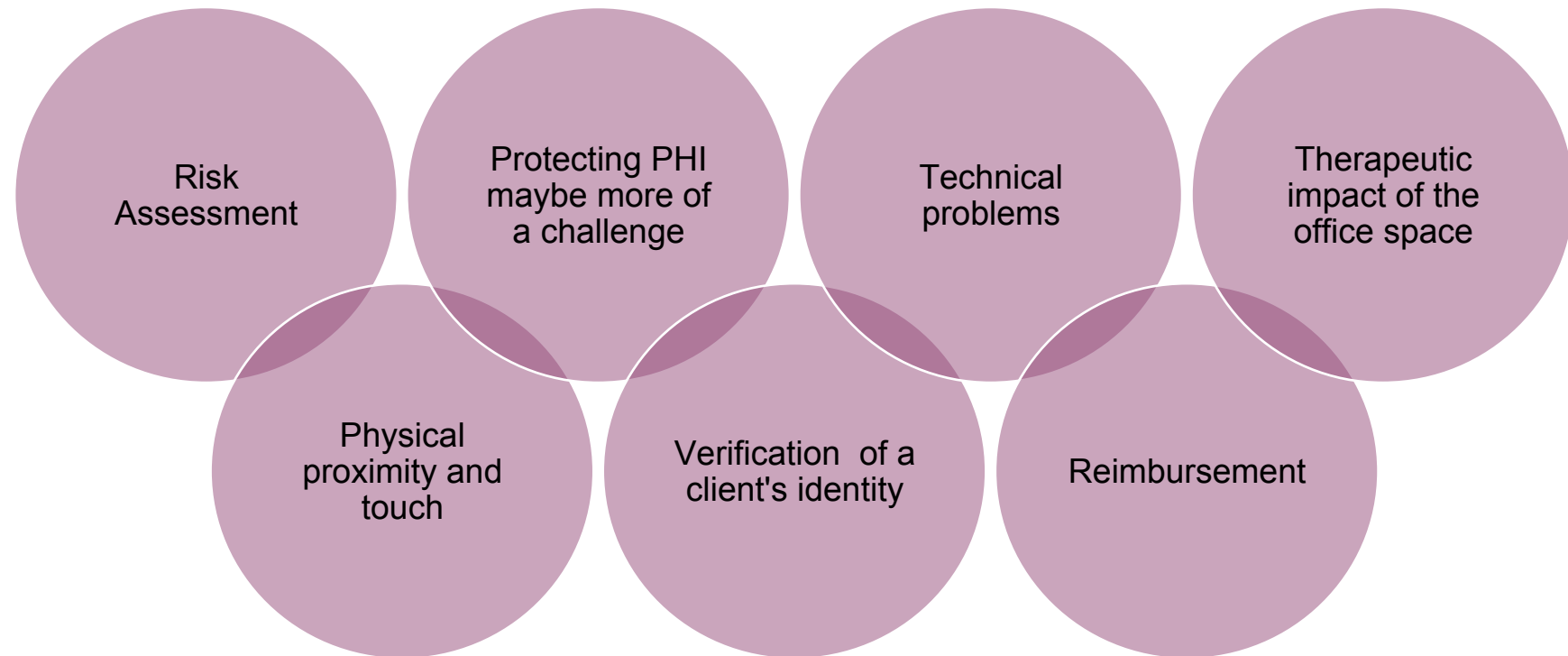
Therapy only works if it takes place

Can be used with other online tools

Allows for tracking progress



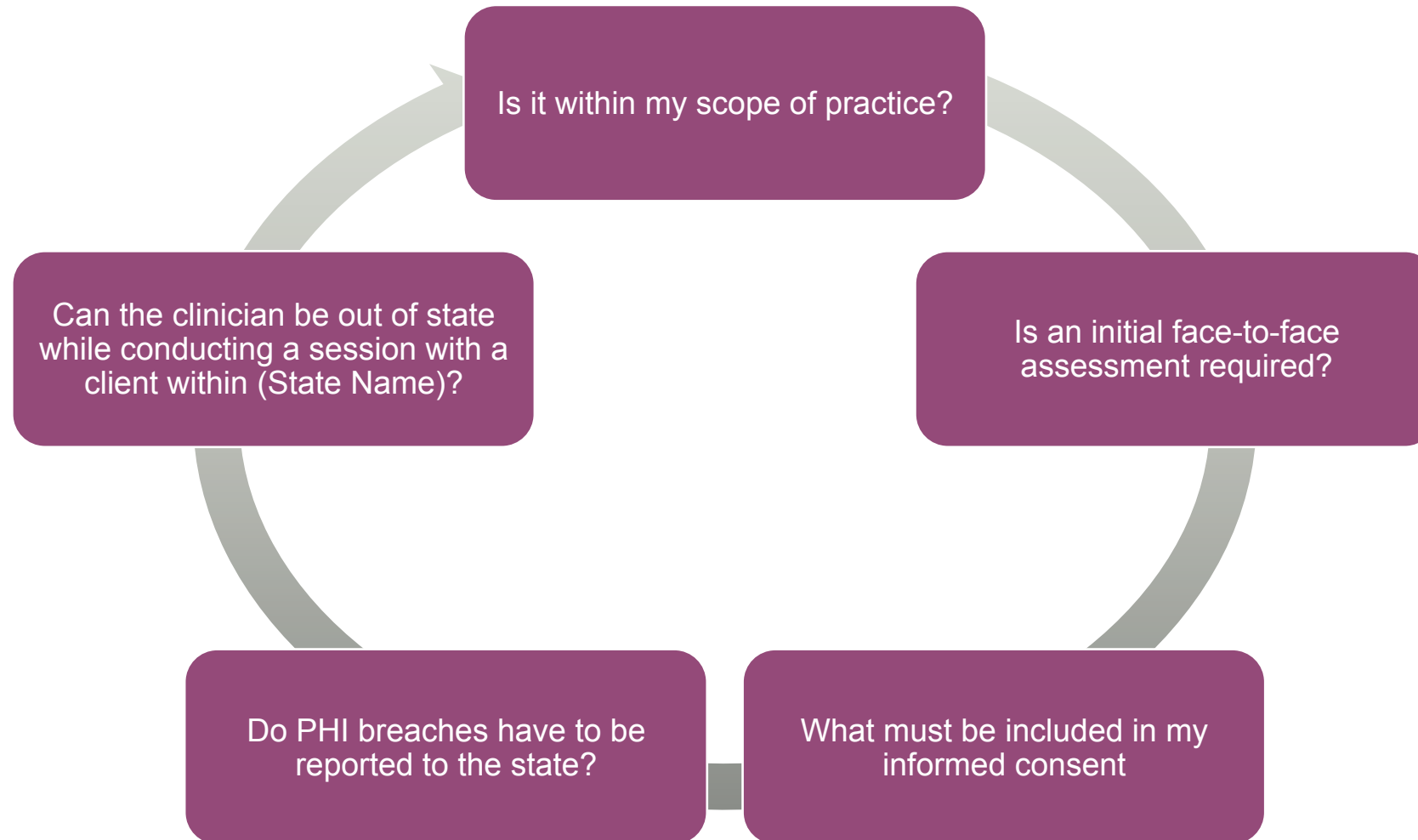
DRAWBACKS TO TELEMENTAL HEALTH



IF I AM A LICENSED MENTAL HEALTH PROFESSIONAL CAN I PROVIDE DISTANCE COUNSELING?

- To determine if you are allowed to practice psychotherapy from a distance using a specific medium of communication you should contact your licensing board.
- Items you will want to know are:
 - The definition of your practice
 - Whether or not the service you want to provide and how you want to provide it is within your scope of practice.
 - What are the rules and regulations around providing telemental health?

WHAT TO ASK YOUR STATE BOARD:





CONSIDERATIONS

Professional liability insurance

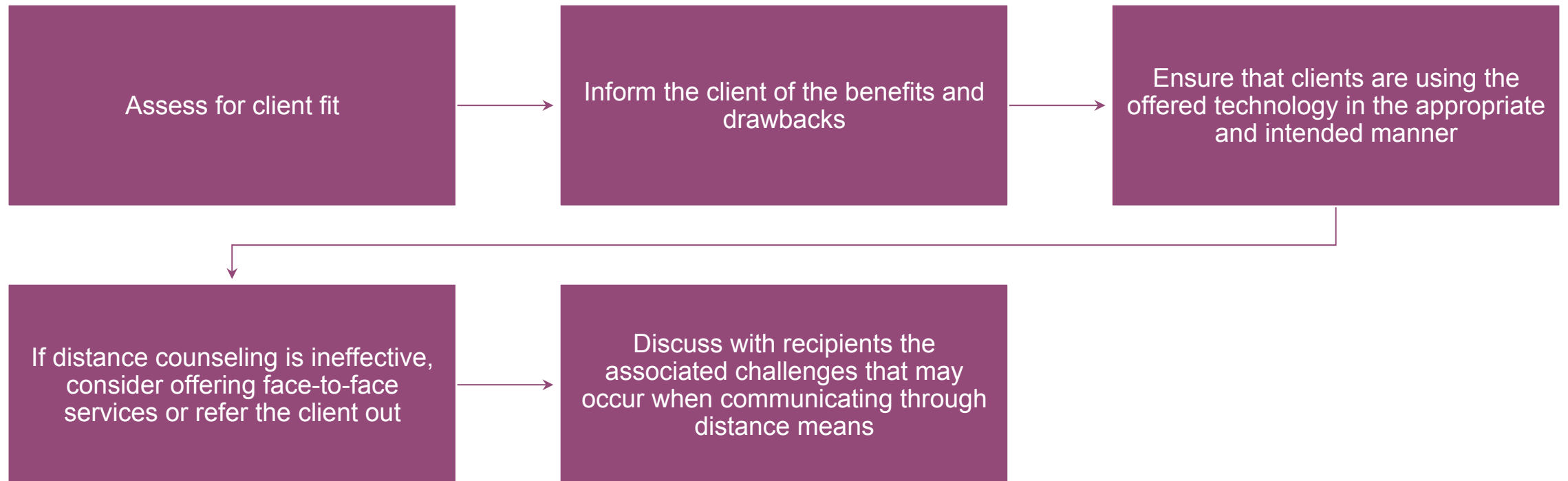
Verify the client's identity at the start and throughout the counseling process

Verify your identity and licensure

Adhere to state laws regarding telehealth and licensure

Ensure clients are aware of pertinent legal rights and limitations governing the practice of counseling across state lines or international boundaries

PREPARING CLIENTS FOR SUCCESS





PREPARING CLINICIANS FOR SUCCESS

Conduct oneself in a professional manner during distance counseling sessions as if the client were in your office



Only communicate with clients in environments that can reasonably ensure client privacy



Protect from unwanted interruption



COMPETENCE



Practice within boundaries of competence

Obtain appropriate study, training, consultation and supervision

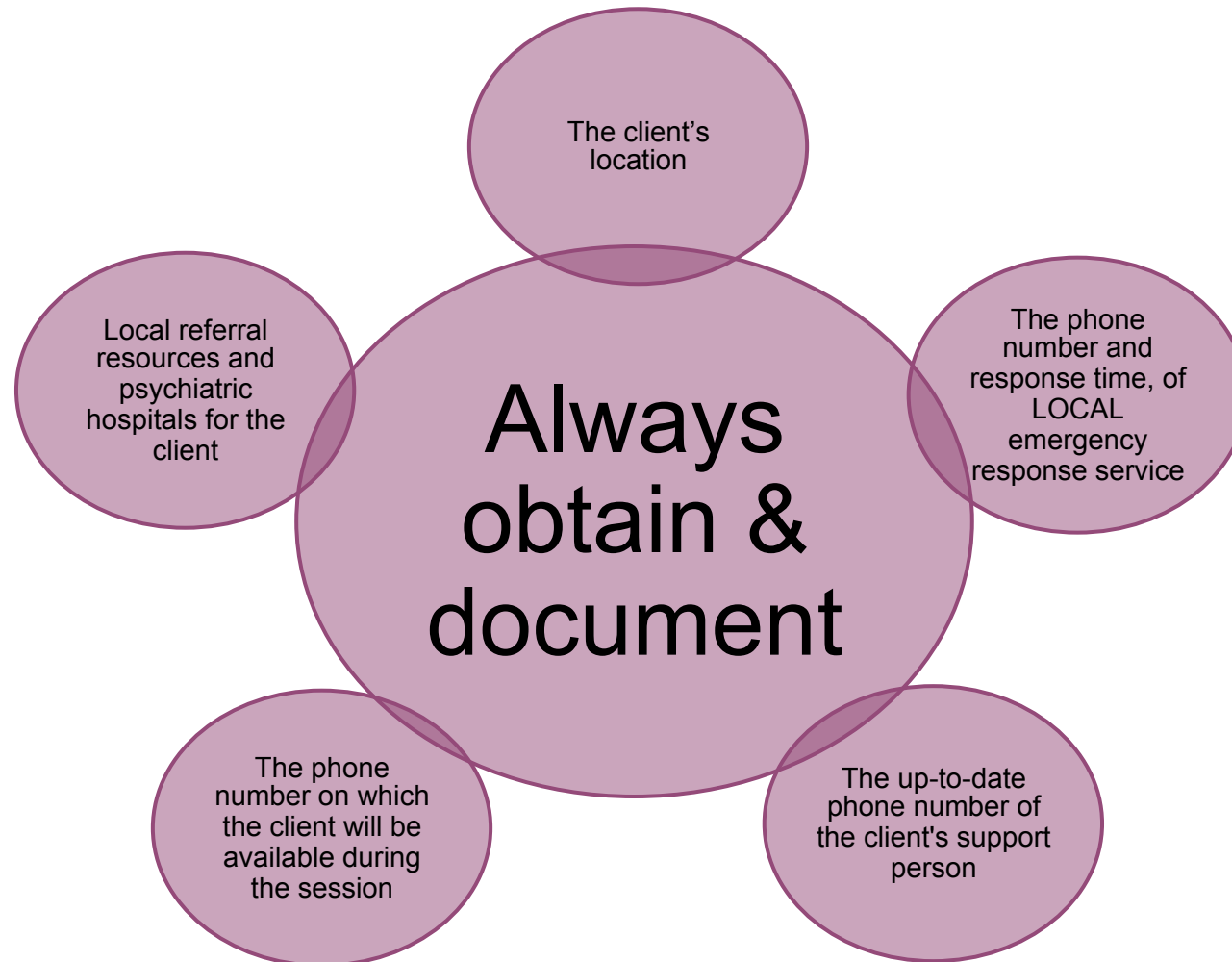
Adhere to standards and use careful judgment and responsibility to ensure competence

Have an emergency management plan for each session with a client

Choose technological platforms that adhere to standards of best practices and meet applicable laws



SAFEGUARDS



TELEMENTAL HEALTH TRAININGS



HIPAA COMPLIANT PLATFORMS



NON HIPAA COMPLIANT PLATFORMS



SHORT CUTS PUT EVERYONE AT RISK

- Detrimental to the wellbeing of clients
- Risk to therapists
 - Malpractice may not cover you
 - License sanctions
 - Legal repercussions
- Being informed consumers and provides is important particularly now
- *If you can't do it the right way, refer to someone who is doing it the right way.*

SELECTED REFERENCES

- Aardoom, J. J., Dingemans, A. E., & Van Furth, E. F. (2016). E-Health interventions for eating disorders: Emerging findings, issues, and opportunities. *Current Psychiatry Report*, 18(4), 42. <https://doi.org/10.1007/s11920-016-0673-6>
- Anderson, K. E., Byrne, C. E., Crosby, R. D., Le Grange, D. (2017). Utilizing telehealth to deliver family-based treatment for adolescent anorexia nervosa. *International Journal of Eating Disorders*, 50(10), 1235-1238.
- Gulec, H., Moessner, M., Mezei, A., Kohls, E., Túry, F., & Bauer, S. (2011). Internet-based maintenance treatment for patients with eating disorders. *Professional Psychology: Research and Practice*, 42(6), 479-486. <http://dx.doi.org/10.1037/a0025806>

THANK YOU!

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**Patients need treatment that is available
anytime, anywhere**



Why Do Patients Feel so at Home on Their Phone?



- **Smartphone proliferation** - 81% of population* has one
- **Convenience** - 95% use their phones in restaurants
- **Text or bust** - Teens send on average 70 texts per day
- **Data Gen** - Quantified self movement has normalized “tracking”
- **(False?) Privacy** - Search queries for stigmatized health issues are 5 times higher on mobile than on desktop

*81% owner a smartphone; 96% a mobile phone according to Pew Research - <https://www.pewinternet.org/fact-sheet/mobile/>

Poll Question

What percentage of your patients do you estimate have used a calorie counting app?

A. 15%

B. 50%

C. 75%

D. 95%

Eating disorder treatment is missing data

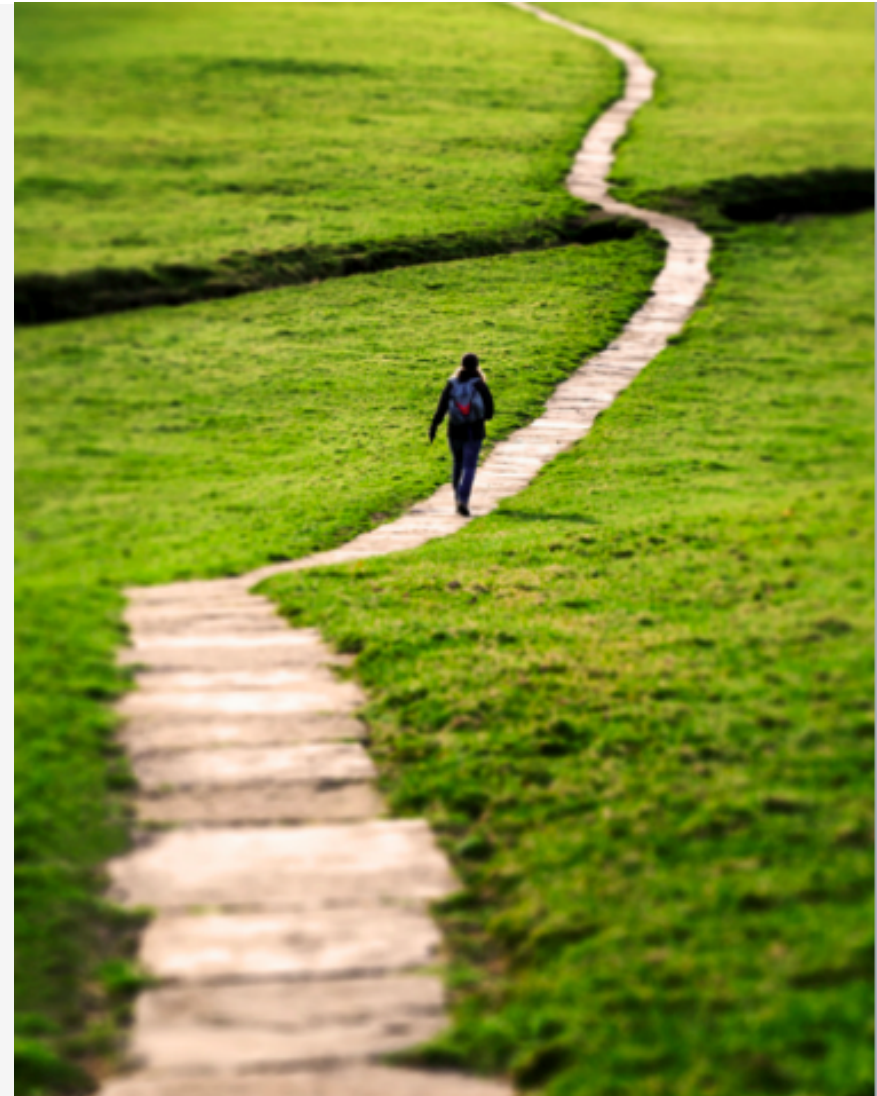


Self-Monitoring is Best Practice

- ❑ **Adherence to homework tasks is associated with improved outcomes in CBT** (Kazantzis, Deane, & Ronan, 2002)
- ❑ **The more consistent the monitoring, the better the treatment outcomes** (Baker & Kirschenbaum, 1993)
- ❑ **Self-monitoring food intake can decrease binge eating in the absence of any other intervention** (Latner & Wilson, 2002)
- ❑ **DBT Diary Card based treatment results in large significant improvements in binge eating and bulimic symptoms** (Klein, Skinner & Hawley, 2013)

What Makes Self Monitoring Effective?

- ❑ Patient, Primary Therapist and Dietitian become experts in the unique nature of the patient's disordered eating and cognitions
- ❑ Uncovers insights into personal maintaining factors and triggers
- ❑ Reminders routinize regular eating
- ❑ Opportunity for delay between urge and response
- ❑ Coping skill activation and acquisition



This Is Not Congruent With Patients' Digital Lives

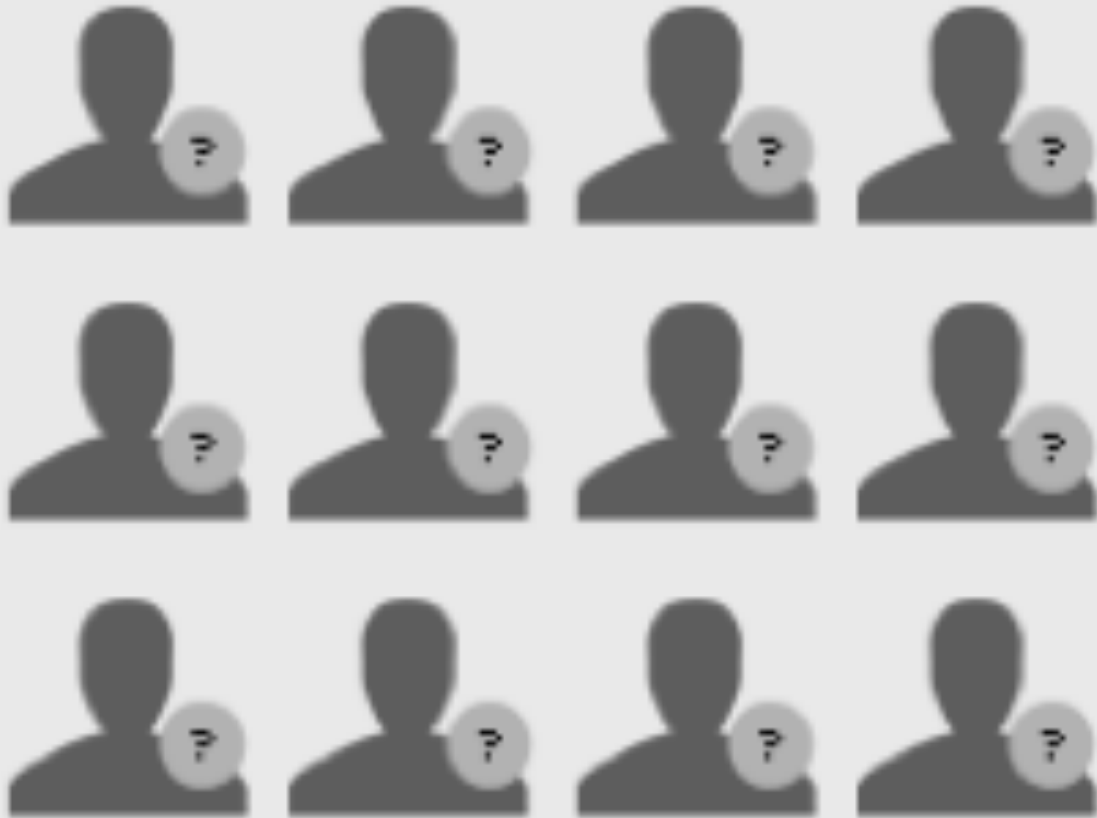
DAILY FOOD RECORD

NAME Jane Summers. DAY Monday DATE 1/14/2013.

TIME	FOOD AND LIQUID CONSUMED	PLACE	MEAL (M) SNACK (S) BINGE (B) PURGE (V, L)	CIRCUMSTANCES
8:40am	2 cups coffee, 1 apple yogurt and granola	home	(M)/(B)(V)	Didn't sleep well, woke up stressed about seeing boss at work. Now going to get better.

Poor homework compliance is a robust predictor of treatment engagement and outcomes. So ... should we adapt, or should we ask our patients to?

Turning the Light on for Patients and Providers



The Recovery Record Platform

**Elevate patient
treatment engagement**

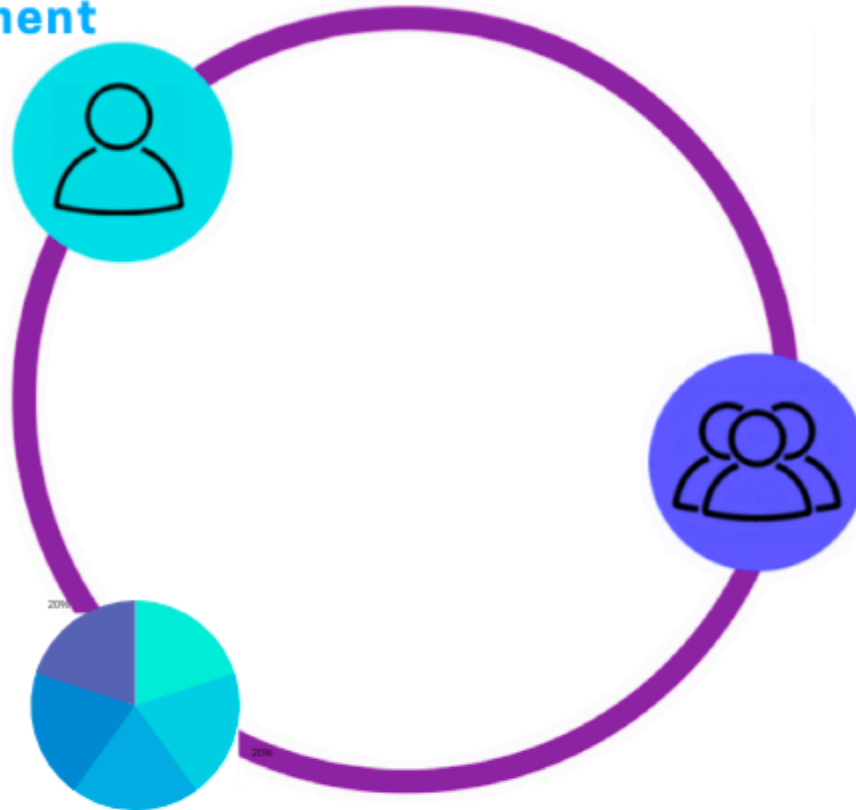


Patient app on iPhone,
Android and Desktop

**Clinician app tracks
patient progress**



Care team app on
iPhone, Android,
Desktop and Tablet



Insights Dashboard

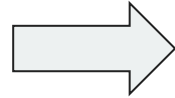
Real time, clinic-wide outcomes and
engagement reporting

A photograph showing the silhouettes of three people standing outdoors at sunset. The sun is low on the horizon, creating a bright, glowing light that silhouettes the figures. The person on the left has their right arm raised in a peace sign. The person in the middle has both arms raised, forming a heart shape with their hands. The person on the right has their right arm raised in a peace sign. The background shows dark silhouettes of trees and a building with a chimney.

**900,000 individuals with eating disorders
have completed over 40 million
self-monitoring entries on Recovery Record**

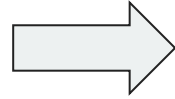
How Does this Change Care?

Reactive



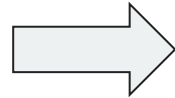
Proactive

Episodic



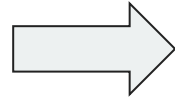
Continuous

Inaccurate verbal recall



(More) accurate real-time report

Subjective outcomes



Standardized outcomes

Pre and Post Pilot Implementation Results

WITHOUT RR

100% Find self-monitoring challenging

0.5 Avg. self-monitoring entries per day

26 Minutes in session covering what happened between visits

12% Can support patients outside clinic

WITH RR

14% Find self-monitoring challenging

2.7 Avg. self-monitoring entries per day

11 Minutes in session covering what happened between visits

100% Can support patients outside clinic

What Makes a Patient a Good Candidate?



Get Out in Front of Common Patient Barriers


- Fear of heightened preoccupation with food
- Not ready to let go of the eating disorder (treatment resistance)
- Fear of judgement or punishment - will you be disappointed in me?
- Uncertainty about when/how data is used
- Worried about being "outed" or data privacy
- Shame

What Recovery Record is NOT

- Should not be used to report emergencies
- Clinicians are not expected to be aware of or respond to patient reported events in the app, except in session or as the clinician chooses
- A replacement for participating and sharing in session
- A complete and accurate record of all dietary intake
- A complete and accurate record of all disordered behaviors
- Easy for patients ... the work of facing into recovery multiple times per day is still hard!
 - Problem-solve around completion issues, keeping shame in mind
 - Praise completion,
 - Nonjudgmentally and collaboratively draw upon patient data in your work



Let's see how it works!



Case Study: BALANCE eating disorder treatment center™

- How One Outpatient Treatment Center Converted to All Virtual Treatment in Response to the COVID-19 Crisis

BALANCE eating disorder treatment center™

Day Program (PHP)

30 hours
per week

IOP (M, W, Th)

Sat Program

9 - 15 hrs
per week

Weekly
Groups (4)

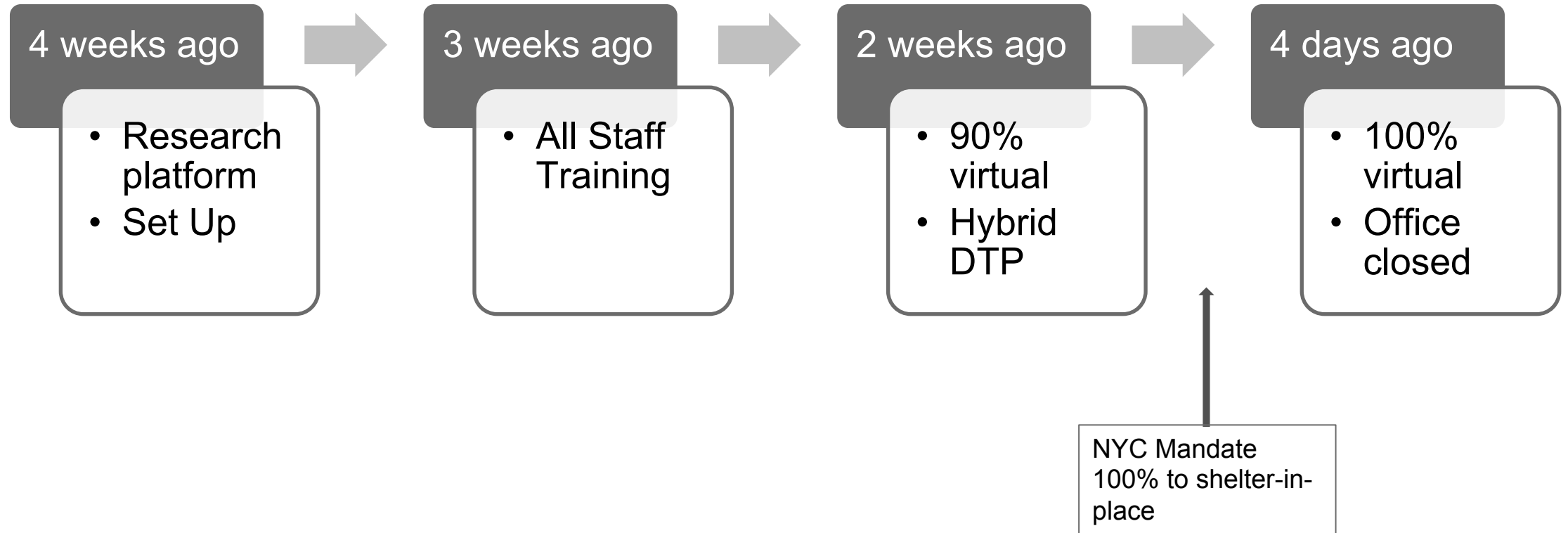
Meal
Supports

Individual
Services

1-1.5 hrs
per week

100+ clients; 100+ hours of
programming

Timeline to go virtual



COVID-19: How one outpatient treatment center converted to all virtual services

- **Fifth Stage: Challenges**
 - **Doxy not reliable** with increase in volume
 - Challenge with finding comparable HIPPA platform
 - **NYS relaxes HIPPA requirement for all telehealth**
 - **Allows us to pivot to Zoom, Google Classroom, and Doxy** depending upon reliability of service at that time
 - Currently: Doxy for individual sessions, Zoom for groups and team meetings.

COVID-19: How one outpatient treatment center converted to all virtual services

- What we have learned;
 - Clients were **initially reluctant** to adapt the virtual services and some threatened to drop out (our most ill clients, perhaps predictably!)
 - Once New York City was shut down, and it was too risky to offer in-person, **clients embraced the change** and are now SO appreciative of the virtual services (!)

COVID-19: How one outpatient treatment center converted to all virtual services

- What we have learned;
 - Had **2 clinicians sign in for each group** – in case there was a tech issue, one could run the group while the other could problem solve
 - Needed to have **all clients contact info on hand** (email/ cell to text) if there was a tech problem and needed to switch platforms
 - Need all of your **work materials available to email / download** for your clients to access

COVID-19: How one outpatient treatment center converted to all virtual services

- **What we have learned;**
 - **Meal support** extra difficult for obvious reasons
 - Therefore did a **portioning training** for the clients
 - Have **extra staff on group sessions** to be able to have “eyes” on each client
 - **Easing back slightly on intensity of food exposures**, as dealing with added stress of being at home / isolation / facing a crisis
 - **Relying also on Recovery Records more than ever** to “fill in the gaps” with meal compliance and food behaviors
 - Case-by-case on **how to handle weigh-ins** (EG not doing for now; virtual “backward” weigh in during session; family member weighs client; exposure therapy opportunity per CBT/FTB)

COVID-19: How one outpatient treatment center converted to all virtual services

- **What we have learned;**
 - Clients in group settings – learning to deal with flexibility if time lag with video
 - Affects dynamic with having to be deliberate with taking turns to speak
 - Extra level of work for our clinicians

RR App Uptake and Engagement

- 12 clinical staff (Dietitians and Primary Therapists) linked with 267 patients with varying ages and diagnoses.
- Patients logged **3.7 self-monitoring entries per day** on average
- **71% of patients completed therapy homework daily**
 - This surpasses pen and paper compliance, which is 10.9% on average (Stone et al., 2003)

Introducing RR to Clients

- *“It's a way to log what your eating in a recovery minded way rather than a disorder "diet-y" way (such as My Fitness Pal). If nothing else, lets just add pictures”*
- *“This is a useful tool for you to help you **get a better understanding of how you are feeling**, and how your feelings may be impacting eating behaviors”*
- *“Do your best to **post pictures** and **fill out in real time** and whatever you struggle with will be good days for us to explore in our next session”*
- *“This a great tool for us as your recovery support team to support you with any **food or body judgments** that come up and work together to identify themes in your relationship with food that you want to work on”*

What Clinical Clues Can the Data Reveal?

1. Consistency with meal intake, time between meals, completion of meals, and emotional triggers.
2. Common feelings around eating
3. Portion sizes, variety
4. Hunger and fullness
5. Pictures for meals / food / plating
6. **Thought Log:** Black and white thinking/food judgments/body judgments

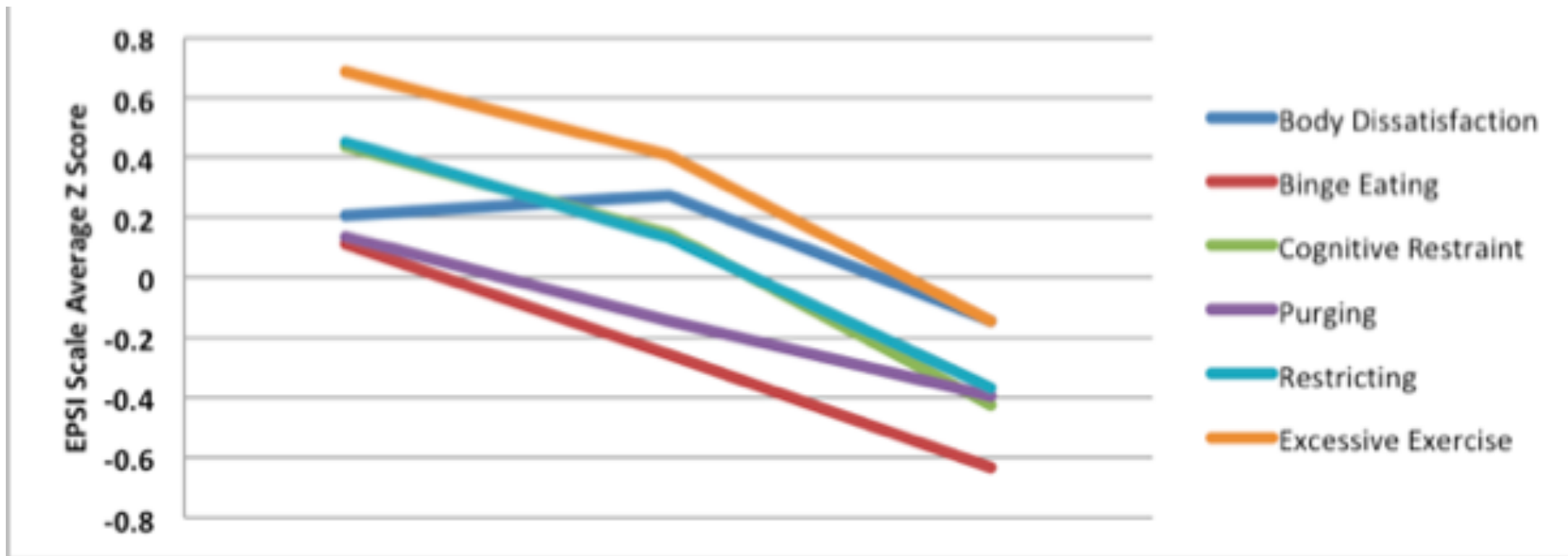
My Team: 100% like it, and 90% would recommend it to other providers

What Did Staff Find Most Challenging?

- Keeping clients **engaged** and recording regularly
- Managing client **expectations** for constant feedback from clinicians all week long
- Questioning **accuracy** of information portrayed
- Learning a new App and its **functionality**
- The stress of having **so many logs** to keep up with
- Sometimes there are **a lot of text** to get through
- **Another thing to do** in the day

Automating Outcome Collection via RR

The EPSI questionnaire is automatically collected in-app and scored at admission and every month thereafter.



There were statistically and clinically significant improvements across all areas of pathology from baseline (admission) to month two, to month three.

Thank you!

Questions?

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