phn BRISBANE SOUTH
An Australian Government Initiative

National Eating Disorders Collaboration

QUALITY IMPROVEMENT TOOLKIT
FOR GENERAL PRACTICE

Mental health

Eating disorders
MODULE

Version 2

Introduction

The Quality Improvement Toolkit

This Quality Improvement (QI) Toolkit is made up of modules that are **designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients.** The Toolkit will help your practice complete Quality Improvement (QI) activities using the Model for Improvement.

Throughout the modules, you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the Model for Improvement.

The Model for Improvement uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- It is a simple approach that anyone can apply.
- It reduces risk by starting small.
- It can be used to help plan, develop and implement highly effective change.

The Model for Improvement helps you break down your change into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted.

There is an example eating disorder plan using the Model for Improvement and a blank template for you to complete at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on optimalcare@bsphn.org.au

This icon indicates that the information relates to the ten Practice Incentive Program (PIP) Quality Improvement (QI) measures.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

Acknowledgements

We would like to acknowledge that some material contained in this Toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; Medical Director, CAT4; and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

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Brisbane South PHN would like to acknowledge the contribution of the National Eating Disorders Collaboration (NEDC) in the production of this QI toolkit. The NEDC have provided resources, program framework and publications to assist general practice to identify, support and medically manage people with an eating disorder.

Brisbane South PHN, 2020

Contents

Mental health – eating disorders

Eating disorder QI toolkit goals and objectives

This toolkit is to be used in general practice to:

- Identify those patients in your practice with and at risk of an eating disorder, including screening and assessment of those with relevant comorbidities or presentations
- Develop a register of patients with an eating disorder to facilitate better continuity of care (reminders, recalls)
- Increase your ability to better manage the physical and mental health of patients with an eating disorder
- Support prevention, early identification, appropriate intervention and referral of patients with and at risk of an eating disorder
- Identify patients eligible for MBS eating disorder and other funding streams.

What is an eating disorder?

An eating disorder is a serious and complex mental illness, characterised by food, eating, exercise and body weight or shape and the control of these becoming an unhealthy preoccupation of someone's life.

Eating disorders are not a lifestyle choice, a diet gone wrong or a cry for attention. Eating disorders can be present at any weight. They take many different forms and impair a person's day to day functioning.

Without appropriate intervention as early as possible in the course of illness, eating disorders are likely to persist long term, with life-threatening physical and psychological complications.

Behavioural warning signs

Behavioural warning signs for eating disorders include:

- constant or repetitive dieting (e.g. counting calories/kilojoules, skipping meals, fasting, avoidance of certain food groups or types such as meat or dairy, replacing meals with fluids, adherence to dietary or 'lifestyle' choices with idiosyncratic and rigid rules, under dosing Insulin if Type 1 diabetes present)
- evidence of binge eating (e.g. disappearance of large amounts of food from the cupboard or fridge, food wrappers appearing in bin or in other hiding places, hoarding of food in preparation for binge eating)
- evidence of vomiting or laxative abuse for weight control purposes (e.g. frequent trips to the bathroom during or shortly after meals, regular purchasing of high volumes of laxatives, expectorants or other related pharmaceuticals)
- excessive or compulsive exercise patterns (e.g. exercising when injured or in bad weather, refusal to interrupt exercise for any reason, insistence on performing a certain number of repetitions of exercises, exhibiting distress if unable to exercise)
- development of patterns or obsessive rituals around food, food preparation and eating (e.g. insisting meals must always be at a certain time, only using a certain knife, only drinking out of a certain cup, cutting foods into a certain number of pieces)
- changes in food preferences (e.g. refusing to eat certain foods, claiming to dislike foods previously enjoyed, sudden interest in 'healthy or clean eating', making lists of 'good' and 'bad' foods)
- eating very slowly (e.g. eating with teaspoons, cutting food into small pieces and eating one at a time, rearranging food on plate)

- attempted avoidance of all social situations (including family meals at home) involving food, bringing own food to social events, or refusal of food in social settings (e.g. not sharing in a birthday cake)
- social withdrawal or isolation from friends, including avoidance of previously enjoyed activities
- frequent avoidance of eating meals by giving excuses (e.g. claiming they have already eaten or have an intolerance/allergy to particular foods)
- deceptive behaviour around food (e.g. lying about amount or type of food consumed, secretly throwing food out, eating in secret often only noticed due to wrappers or food containers found in the bin)
- behaviours focused around food preparation and planning (e.g. shopping for food, planning, preparing and cooking meals for others but not personally consuming, taking control of the family meals, reading cookbooks, recipes, nutritional guides)
- strong focus on body shape and weight (e.g. interest in weight-loss or muscle-building websites, dieting or bulking tips in books and magazines, images of thin or muscular people)
- development of repetitive or obsessive body checking behaviours (e.g. pinching waist or wrists, repeated weighing of self, excessive time spent looking in mirrors or other reflective surfaces)
- change in clothing style (e.g. wearing baggy clothes or more layers than appropriate for the weather)
- inappropriate hydration behaviours (e.g. consuming little to no fluids, consuming excessive fluids above requirements)
- continual denial of hunger.

Physical warning signs

Physical warning signs for eating disorders include:

- sudden or rapid weight loss or weight gain
- frequent changes in weight
- sensitivity to the cold (feeling cold most of the time, even in warm environments)
- delayed onset, loss or disturbance of menstrual periods (females) or reduced morning tumescence (males)
- signs of frequent vomiting — swollen cheeks or jawline, calluses on knuckles, damage to teeth
- fainting, dizziness
- fatigue —always feeling tired, unable to perform normal activities
- gastrointestinal disturbances with no clear cause (e.g. gastroesophageal reflux, bloating, constipation, nausea, early satiety)
- hair loss/thinning on the head
- increase of body hair growth
- chest pain, heart palpitations
- postural tachycardia
- low blood sugar
- changes in blood pressure
- lab investigations (e.g. anaemia, low or high potassium, sodium, bicarbonate, calcium, albumin).

For a more extensive list of physical warning signs and useful laboratory investigations please refer to the RACGP early detection of eating disorders and AED Medical Standards Guides.

Psychological warning signs

Psychological warning signs for eating disorders include:

- increased preoccupation with body shape, weight and appearance
- intense fear of gaining weight
- constant preoccupation with food or with activities relating to food
- extreme body dissatisfaction/negative body image
- distorted body image (e.g. complaining of being, feeling or looking fat, or complaining of lacking muscle definition, strength or bulk)
- heightened sensitivity to comments or criticism (real or perceived) about body shape or weight, eating or exercise habits
- heightened anxiety around meal times
- depression or anxiety, self-harm or suicidality
- moodiness or irritability
- low self-esteem (e.g. feeling worthless, feelings of shame, guilt or self-loathing)
- rigid 'black and white' thinking (viewing everything as either 'good' or 'bad')
- feelings of life being 'out of control'
- feelings of being unable to control behaviours around food[1].

Feed Your Instinct has a checklist available for a GP or Practice nurse to use to ask a young person about their food choices, eating patterns and attitudes towards nutrition.

Classifying eating disorders - DSM 5

Within the medical profession, eating disorders are usually clinically defined and diagnosed according to the criteria laid out in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5).

The DSM-5 recognises the following eating disorder diagnosis:

- anorexia nervosa
- bulimia nervosa
- binge eating disorder
- avoidant/restrictive food intake disorder (ARFID)
- pica
- rumination disorder
- other specified feeding or eating disorder (OSFED)
- unspecified feeding and eating disorders (UFED).

Early detection of eating disorders in general practice provides more information about classifications, reviewing the DSM-5 and the general practice consultation.

[1] https://www.eatingdisorders.org.au/eating-disorders-a-z/what-is-an-eating-disorder/

Impact of eating disorders

Bulimia nervosa and anorexia nervosa are the eighth and tenth leading causes respectively of burden of disease and injury in females aged 15-24 in Australia.

The mortality rate for people with eating disorders is up to six times higher than that for people without eating disorders. This includes an increased risk of suicide.

Lifetime prevalence is approximately 9% of the total population,[2] with binge eating disorder and OSFED the most prevalent disorders in Australia.[3] Due to their potential severity, eating disorders also contribute to significant healthcare costs. Approximately 20% of people with anorexia remain chronically ill for the long term.[4]

However, with appropriate treatment recovery is achievable. Evidence shows that early identification, access to person-centred and evidence-based treatment can reduce the severity, duration and impact of the illness.

Eating disorders and suicide

Eating disorders wreak havoc on the mind and the body. Suicide is a major cause of mortality for people with eating disorders and is up to 31 times more likely to occur for someone with an eating disorder. [5]

Research shows that quality mental health care can reduce suicidal thinking and prevent suicidal behaviour. It is important that clinicians are equipped with skills to discuss suicide and suicide risk with their patients. More information about training options can be found here. This involves a comprehensive psychosocial assessment and assessment of suicidality.[6]

[2] https://www.nedc.com.au/research-and-resources/show/an-integrated-response-to-complexity-national-eating-disorders-framework

[3] Hay P, Mitchison D, Collado AEL, Gonzalez-Chica DA, Stocks N & Touyz S. 'Burden and health-related quality of life of eating disorders, including Avoidant/Restrictive Food Intake Disorder (ARFID), in the Australian population', J Eat Disord, 2017; 5:21. DOI: 10.1186/s40337-017-0149-z

[4] https://www.nedc.com.au/research-and-resources/show/what-are-the-major-drivers-of-prevalent-disability-burden-in-young-australians

[5] Preti AR, Camboni MV, & Miorro P. A comprehensive meta-analysis of the risk of suicide in eating disorders. Acta Psychiatr Scand 2011; 124:6-17. DOI: 10.1111/j.1600-0447.2010.01641.x

[6] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/red-book/psychosocial/suicide

Activity 1 - Understanding your patient eating disorder profile

Activity 1.1 – Data collection from clinical software package

The aim of this activity is to collect data to identify patients diagnosed with an eating disorder at your practice.

Complete the below table by collecting data from your clinical software package.

Note - Instructions on how to extract the data is available from Best Practice *(search under conditions tab)* and Medical Director *(search under conditions tab)*.

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
1.1a	Number of active patient population		
1.1b	Number of active patients (i.e.: 3 x visits in 2 years) See instructions in link below Identify active patients with at least 3 visits in the last 2 years		
1.1c	Number of patients with anorexia nervosa		
1.1d	Number of patients with bulimia or bulimia nervosa		
1.1e	Number of patients with an eating disorder		

Reflection on Activity 1.1:

Practice name:	Date:
Team member:	

Eating disorders and other mental illnesses

Eating disorders commonly occur with other mental illnesses including depression, anxiety, substance use disorders, and personality disorders. Brisbane South PHN have other mental health QI toolkits that you can use to identify patient populations that may warrant eating disorder screening.

Activity 1.2 – Data collection from clinical software package

The aim of this activity is to collect data to identify patients diagnosed with an eating disorder plus another mental illness at your practice.

Complete the below table by collecting data from your clinical software package.

Note - Instructions on how to extract the data is available from Best Practice *(search under conditions tab)* and Medical Director *(search under conditions tab)*.

	Description	Total number of active patients
1.2a	Number of patients with an eating disorder and anxiety	
1.2b	Number of patients with an eating disorder and depression	
1.2c	Number of patients with an eating disorder and substance abuse	
1.2d	Number of patients with anxiety (Refer to the anxiety and depression QI toolkit for activities for these patients)	
1.2e	Number of patients with depression (Refer to the anxiety and depression QI toolkit for activities for these patients)	

Reflection on Activity 1.2:

Practice name:	Date:
Team member:	

Activity 1.3 – Reviewing your practice eating disorder profile

Complete the checklist below to review your patients with a known eating disorder.

Description	Status	Action to be taken
After completing activity 1.1, are there any unexpected results with your practice's eating disorder profile?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients recorded with an eating disorder than expected)* How will this information be communicated to the practice team?

Description	Status	Action to be taken
After completing activity 1.2, are there any unexpected results with your practice's eating disorder and other mental illnesses profile?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. lower number of patients recorded with anxiety and eating disorder than expected)* How will this information be communicated to the practice team?
After reviewing your practice's eating disorder profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 1.3:

Practice name:	Date:
Team member:	

Activity 2 – Improving practice data measures

Guidelines to the safe collection of patient weight and height data

Weight, height and BMI profile should not be used as a standalone measure to determine presence of an eating disorder. Weight alone is an unreliable measure and has to be used in the context of weight history, weight controlling behaviours and medical stability, alongside a more comprehensive medical assessment.

Collecting a weight for a patient with or at risk of an eating disorder can be a very distressing scenario for the patient. Nonetheless weighing a patient is often necessary for safe medical management.

It is possible another health professional is actively monitoring this metric, in which case identifying who that person is and then determining which member of the treating team will be responsible for ongoing weight monitoring can assist in minimising the patient's anxiety through overly frequent weighing.

The following strategies should be considered before collecting any patient's height, weight and other anthropometric measurements:

- be sensitive and non-judgemental when discussing weight and appearance. Do not make judgements about the patient's aesthetic appearance (e.g. 'You look good') or make inferences about the patient's health behaviour based on their appearance (e.g. 'You've obviously been eating well')
- determine if the patient has recently been weighed by any other health professionals or if they have weighed themselves and make a record of this. Only proceed with weighing if it is purposeful and necessary (i.e. if there is no other health professional regularly monitoring this). Self-monitoring weight or frequent weighing by the patient may be a behavioural warning sign of an eating disorder
- demonstrate empathy, compassion and respect
- obtain explicit patient consent (verbal), or parental consent where relevant. Or, obtain patient consent to talk with the health professional who has been monitoring their weight
- explain to the patient the purpose for collecting this information before proceeding
- if the patient's distress about being weighed is a barrier to medically necessary weighing, or if the patient would prefer not to know their weight, offer to 'blind weigh' the patient so that the results are not visible to them (e.g. step onto the scales backwards, obscure their view of the measurement, obscure their view of the notes if you write it down)
- provide appropriate individual privacy for weighing and confidential discussion of the results
- refrain from any vocal or physical cues, comments or discussing the patient's weight while they are on the scale or post-weighing that may lead them to make any inferences about their weight (e.g. 'You've done well this week', 'interesting', 'great! Thanks')
- complete the medical assessment before discussing the patient's weight if medically necessary, along with general progress, and withholding specific numerical details.

There are some eating disorder treatment modalities which include viewed weighing as a form of exposure therapy and monitoring (e.g. Enhanced Cognitive Therapy),[7] however these should not be undertaken by anyone who has not been appropriately trained or does not have adequate support from the multi-disciplinary team and clinical supervision.

[7] Englaish SM. Weighing the options: professionals' weighing procedures in the treatment of eating disorder patients. 2016.

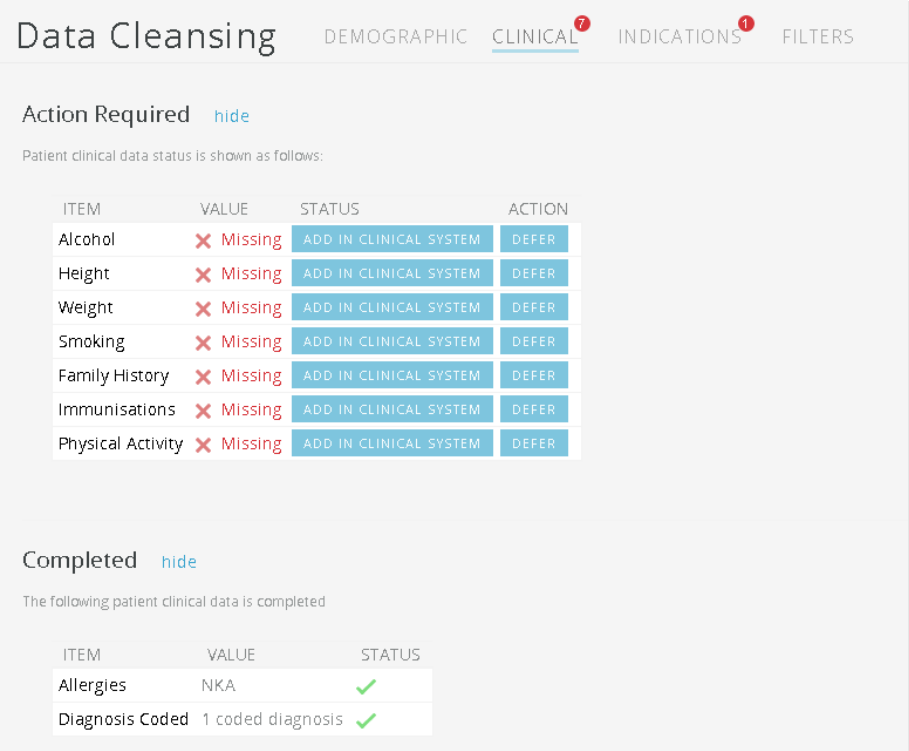
Using CAT4 cleansing view to improve your practice gender, allergies, height, weight, alcohol and smoking status

The Cleansing CAT module allows the easy identification of critical missing patient data by providing a set of predefined reports. These reports provide data that would otherwise require multiple filter selections and recalculation.

Instructions on how to use this report is available from CAT4 website.

Using CAT 4 Clinical Tab Cleansing App to identify missing items

This tab displays any missing and completed items from the patient's record related to the clinical information in their patient record in the GP application. Items that require actions are displayed on top, and completed items at the bottom of the screen. Both can be hidden or displayed by clicking the hide/display link.



Topbar allows the user to jump straight to the relevant field in the GP desktop application by clicking on the ADD IN CLINICAL SYSTEM link on the screen. For more information refer to Pen CAT4 website.

Activity 2.1 – Data collection from CAT4

The aim of this activity is to collect data to identify patients with no height and/or weight recorded at your practice.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Prior to completing this activity, it is recommended that you have read the 'Guidelines to safe collection of patient weight and height data'.

Note - Instructions on how to extract the data is available from the CAT4 website: Add height, weight and BMI.

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
2.1a	Number of patient population from activity 1.1		
2.1b	Number of patients with no weight recorded		
2.1c	Number of patients with no height recorded		
2.1d	Number of patients with no height or weight recorded		

Reflection on Activity 2.1:

Practice name:	Date:
Team member:	

Activity 2.2 – Reviewing your practice height, weight and BMI profile

Complete the checklist below to review your practice's height, weight and BMI profile.

Prior to completing this activity, it is recommended that you have read the 'Guidelines to safe collection of patient weight and height data'.

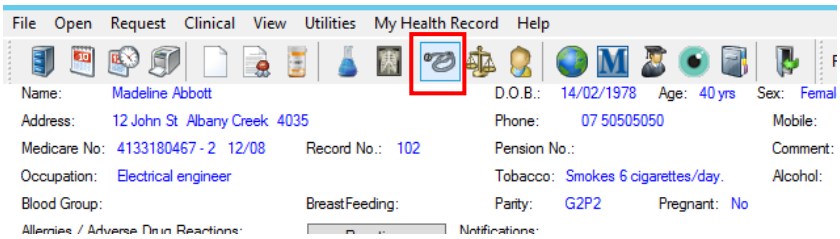
Description	Status	Action to be taken
After completing activity 2.1, are there any unexpected results with your practice's recording of height and weight?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. high number of patients with no weight recorded)* How will this information be communicated to the practice team?
Do relevant team members know where to enter height, weight and BMI in your practice's software?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	See instructions for BP Users. See instructions for MD Users. How will this information be communicated to the practice team?
Do relevant team members know how to set up a Topbar prompt to set a reminder to enter any missing height and/or weight at the patient's next appointment?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the instructions on how to setup a Topbar prompt.
After reviewing your practice's height, weight and BMI profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 2.2:

Practice name:	Date:
Team member:	

Entering height and weight in the patient observations in Best Practice

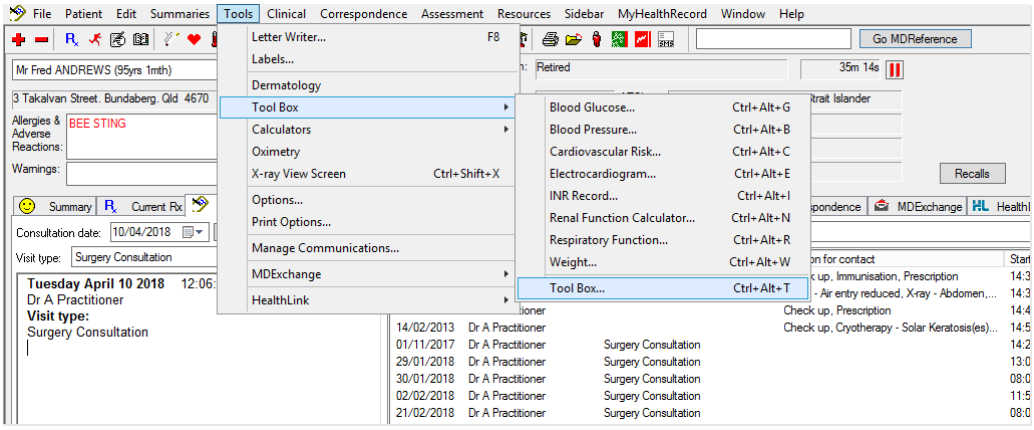
1. Open the patient file.
2. Go to **Clinical** and select **Observations OR** click on the **Observations** icon on the toolbar.

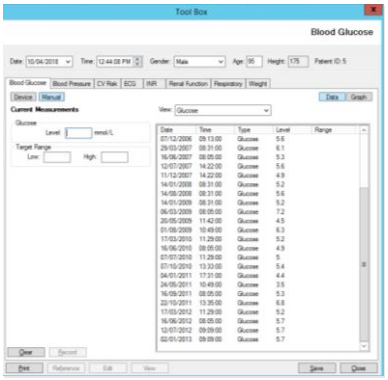


3. This will then open up a screen where you can select from blood glucose, blood pressure, respiratory, weight, height and temperature.
4. Once you have entered the information select **save**.

Entering height and weight in the patient toolbox in Medical Director

1. Open the patient file.
2. Go to **Tools** and select **Tool Box** and then **Tool Box** again.

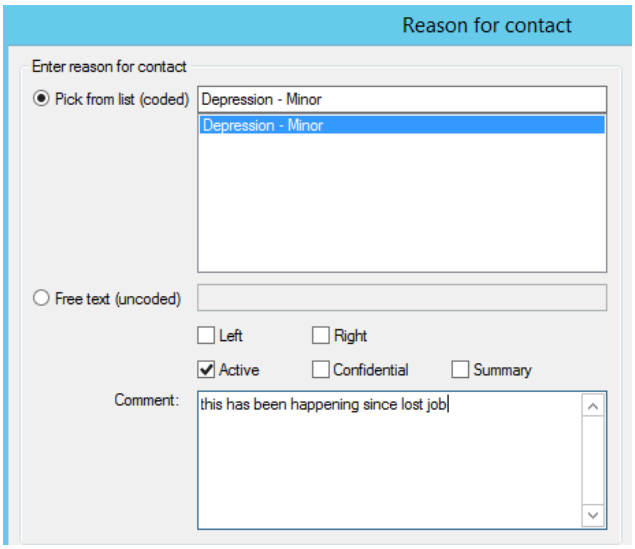




3. This will then open up a screen where you can select weight.
4. Once you have entered the details, select **save.** This information will then be transferred to the patient progress notes for today.

Maintaining your practice's eating disorder database

Coding is simply a process of using an agreed standardised descriptor to store data as a series of numbers or letters. There are multiple ways clinical staff may enter a patient's diagnosis in practice software. Some will type the information directly into the patient progress notes or enter this information as free text in the 'reason for encounter' or 'diagnosis field'. This process is called free texting or un-coded diagnosis. **Free text is not easily searchable in any database by the clinical software or third-party software (e.g. extraction tools).**



If GPs require further information to describe the clinical condition, then include this in a descriptor field (see example image). If a particular coded diagnosis is not available, contact your software provider. You may wish to request that a code be created for each eating disorder diagnosis in the DSM-5 if not already available.

The recommended process is to use a diagnosis from the drop-down boxes provided in the clinical software. This is a coded diagnosis. If all clinical staff within the practice use the same codes to identify a diagnosis then it is easier to search for particular conditions.

It is important to ensure your coding is consistent and agreed upon by all clinical staff in the practice, and diagnostic criteria for eating disorders are uniform.

Advantages and disadvantages of labelling an eating disorder

If someone has an eating disorder diagnosis it is important it is recorded correctly so that the treating team are aware for safety and to allow correct treatment (and to lessen stigma). Any diagnosis should be discussed with the person. Just as we would record a physical health diagnosis, an eating disorder should be recorded if it has been diagnosed. If preferred, it may be marked as confidential, or inactive if no longer of concern.

Recording eating disorders on My Health Record

It may be beneficial to explain to patients the benefits of uploading their diagnosis to My Health Record in supporting effective teamwork with other providers, and to explain that this data cannot be accessed by employers or anyone else outside the patient's healthcare team. Patient's may choose not to upload it to My Health Record if desired.

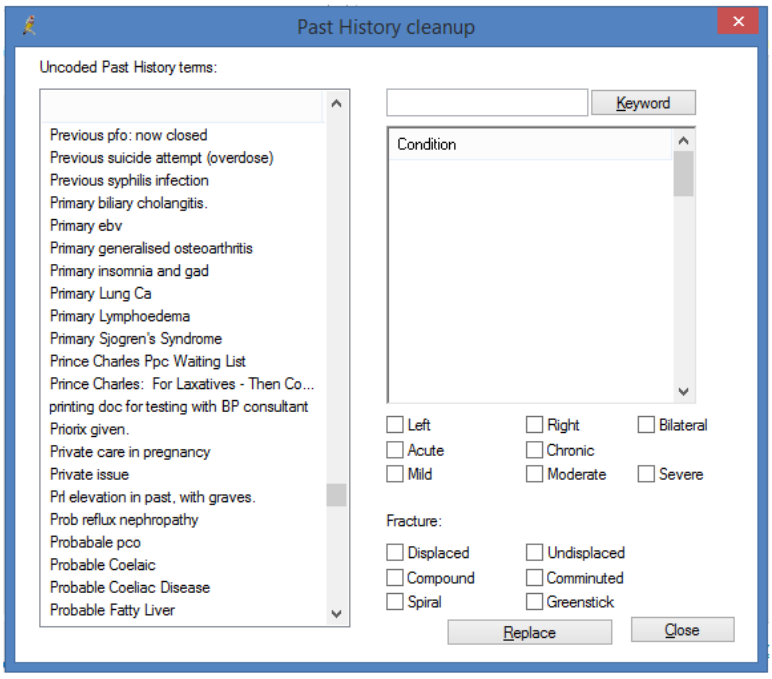
Cleaning up un-coded conditions in your practice software

You can clean up un-coded conditions that have been recorded in your practice software. Cleaning up un-coded items makes it easier to perform database searches and manage third-party clinical audit tools.

*Instructions for cleaning up un-coded conditions in **Best Practice***

It is also possible to clean up un-coded conditions that have been recorded in the **Past History** section of Best Practice. This can assist when performing database searches or using third party Clinical Audit tools.

This clean-up is done via the **BP Utilities** function. Select **Start > Programs > Best Practice Software > Best Practice > BP Utilities**. Select your user name from the drop-down list. You will only have access to this function if you have sufficient user permissions.



Double click on the icon. The **Past History clean-up** screen will appear.

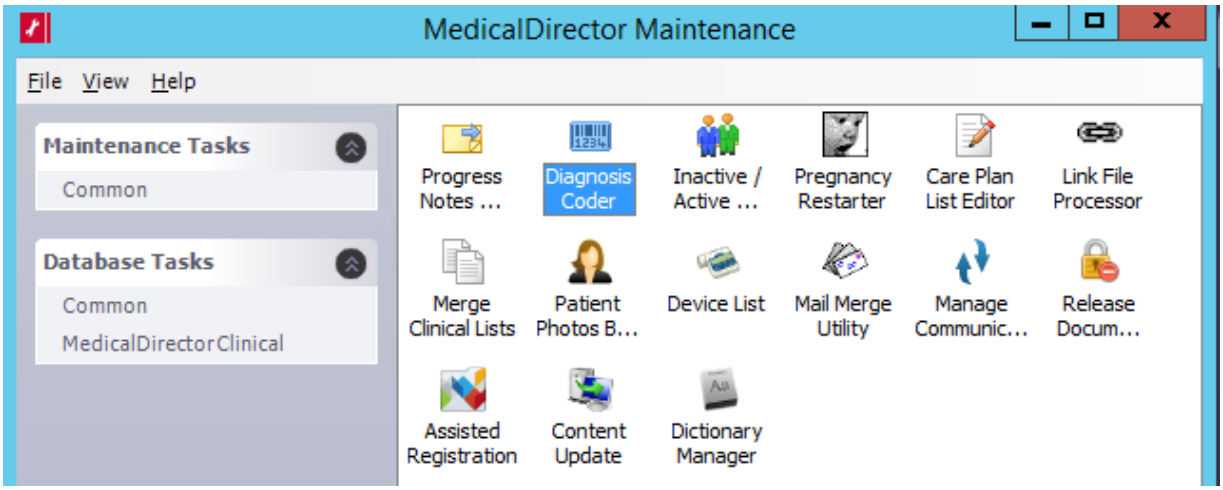
Un-coded Past History is a current list of past history entries entered into the database (usually from a conversion or free texted), and the **Conditions** column is the complete list of coded conditions entered into Best Practice.

On the left-hand side, highlight the item that will be merged to a coded condition. On the right-hand side, enter the coded condition into the keyword search field. Highlight the condition to merge to, then select the replace button.

*Instructions for cleaning up un-coded conditions in **Medical Director***

Medical Director provides a simple utility in **HCN Maintenance** that enables you to easily find un-coded Past Medical History items, and either link them to a coded item or replace them with the correct coded item.

1. Double click the **HCN Maintenance icon** to open HCN Maintenance.
2. Select **Medical Director Clinical** in the list of **Database Tasks** on the left of the window.
3. Double click the **Diagnosis Coder** icon 



The left-hand panel of this screen contains all the un-coded diagnosis entries in the Past Medical History database. The right-hand panel displays coded entries that you will select from to pair with your un-coded entries. Note that the right-hand panel is initially empty, but as you type into the text box above it, a list of items is generated underneath.

Simply highlight the entry on the left and the one you want to link it to or replace it with on the right, and then click either the **Link** or **Correct** button.

The link button will attach the code for that diagnosis to the coded entry on the right. The correct button will change the diagnosis on the left to that on the right (i.e. if the word was misspelled).

Activity 2.3 – Advanced data cleansing tasks

Complete the checklist below to identify if your practice needs to complete further data cleansing tasks.

	Data cleansing task	Current system working well	Current system needs improving	Our practice needs to develop a system
2.3a	Are all patients with an eating disorder coded correctly (*i.e. using the drop-down menus*) in your practice's clinical software program?	☐	☐	☐
2.3b	Has your practice determined terms of consistent coding?	☐	☐	☐

	Data cleansing task	Current system working well	Current system needs improving	Our practice needs to develop a system
2.3c	Has your practice cleaned up any un-coded conditions?	☐	☐	☐
2.3d	Are all patients with an eating disorder marked as active or inactive?	☐	☐	☐
2.3e	Do you have a team member responsible for maintaining the practice database on a regular basis?	☐	☐	☐

Reflection on Activity 2.3:

Practice name:	Date:
Team member:	

Activity 3 – Screening for eating disorders

Patient's with an eating disorder tend to present more frequently to medical services with seemingly unrelated complaints making early detection and diagnosis far more challenging for GPs. These complaints include:

- psychological issues such as stress
- depression or anxiety, or self-harm or suicidal ideation
- requests for assistance with weight loss or weight management
- physical complaints e.g. fatigue, dizziness, gastrointestinal problems (especially constipation and bloating)
- menstrual irregularities
- sleep disturbances
- chronic health problems such as osteoporosis or osteopenia
- cardiac complaints or oedema
- socioeconomic issues e.g. financial insecurity due to inability to sustain employment as a result of the disorder, or pre-existing financial stress leading to food insecurity which can contribute to ED risk. [8]

A classic presentation of an adolescent brought in by a parent who is concerned about their child's nutritional intake, behaviours surrounding food and/or weight (including parental concern if the child has a high body weight), should alert the GP to the possibility of an eating disorder with a more directed history and examination protocol.

Screening high risk groups

Certain conditions may co-occur with an eating disorder or may contribute to the risk profile. These groups should be opportunistically screened:

- people seeking weight loss treatment or dieting
- children and young people
- people who participate in competitive sports and performing arts
- females at any age – particularly during biological & social transition periods (e.g. onset of puberty, change in relationship status, pregnancy and postpartum, menopause, change in social role)
- people experiencing low self-esteem, anxiety, depression or substance misuse
- illness and metabolic conditions – Diabetes (Type 1 and 2) or Polycystic Ovary Syndrome
- people on restrictive diets, with food intolerances or allergies e.g. gluten intolerance
- people with perfectionist or compulsive personality traits
- people with a family history of eating disorders.

[8] https://www.racgp.org.au/afp/2017/november/early-detection-of-eating-disorders/

Screening tools to assist with diagnosis of an eating disorder

There are a number of screening tools that can be used in the primary care setting to assist in the detection and diagnosis of eating disorders. The questionnaires do not diagnose eating disorders, but detect the possible presence of an eating disorder and identify when a more detailed assessment is warranted. The best known of these is the SCOFF questionnaire. There is also the Eating Disorder Screen for Primary Care (ESP).

SCOFF

S – Do you make yourself **S**ick because you feel uncomfortably full?

C – Do you worry you have lost **C**ontrol over how much you eat?

O – Have you recently lost **O**ver 6.35 kg in a three-month period?

F – Do you believe yourself to be **F**at when others say you are too thin?

F – Would you say **F**ood dominates your life?

An answer of 'yes' to two or more questions indicates the need for a more comprehensive assessment.

A further two questions have been shown to indicate a high sensitivity and specificity for bulimia nervosa;

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?

A 'no' for question 1 and a 'yes' for question 2 indicates high suspicion for bulimia nervosa and further questioning is warranted.

Eating Disorder Screen for Primary Care (ESP)

- Are you satisfied with your eating patterns? (A 'no' to this question is classified as an abnormal response).
- Do you ever eat in secret? (A 'yes' to this and all other questions is classified as an abnormal response).
- Does your weight affect the way you feel about yourself?
- Have any members of your family suffered with an eating disorder?
- Do you currently suffer with or have you ever suffered in the past with an eating disorder?

Activity 3.1 – Checklist to review access to screening questionnaires

Complete the checklist below to review your practice's access to screening questionnaires

Questions to consider	Status	Action to be taken
Do all relevant team members know the warning signs for assessing patients at risk of an eating disorder?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Guidelines and information can be obtained from: RACGP, National Eating Disorders Collaboration, or Academy for Eating Disorders (USA).
Do relevant team members have access to screening questionnaires?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Access to SCOFF. Access to ESP. How will this information be made available to all team members?
Do any team members require professional development to support them using these questionnaires?	☐ Yes, **see actions to be taken.** ☐ No, continue with the activity.	Information can be obtained from National Eating Disorders Collaboration.
After reviewing your practice's access to screening questionnaires, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 3.1:

Practice name:	Date:
Team member:	

Assessment of a patient with a suspected eating disorder

A thorough history will also eliminate many of the potential differential diagnoses.

Physical examination and investigations are critical to assess for complications of eating disorders. Once an eating disorder is diagnosed, regular monitoring and treatment is required. The table below summarises a relevant assessment for a patient with a suspected eating disorder.[9]

Assessment of a patient with a suspected eating disorder
The initial physical assessment should include: • height, weight, and body mass index (BMI)(adults) or BMI percentile for age (children) (refer to Guidelines to the safe collection of patient weight and height data) • pulse and blood pressure, with postural measurements • temperature • assessment of breathing and breath (e.g. ketosis) • examination of periphery for circulation and oedema • assessment of skin colour (e.g. anaemia, hypercarotenaemia, cyanosis) • hydration state (e.g. moisture of mucosal membranes, tissue turgor) • examination of head and neck (e.g. parotid swelling, dental enamel erosion, gingivitis, conjunctival injection) • examination of skin, hair and nails (e.g. dry skin, brittle nails, lanugo, dorsal finger callouses/Russell's sign) • sit-up or squat test (i.e. a test of muscle power).
Useful laboratory investigations include: • full blood count • urea and electrolytes, creatinine • liver function tests • blood glucose • urinalysis • electrocardiography • iron studies • B12, folate • calcium, magnesium, phosphate • hormonal testing – thyroid function tests, follicle stimulating hormone, luteinising hormone, oestradiol, prolactin • plain x-rays – useful for identification of bone age in cases of delayed growth

[9] https://www.racgp.org.au/afp/2017/november/early-detection-of-eating-disorders/

Assessment of a patient with a suspected eating disorder
• bone densitometry – relevant after 9-12 months of the disease or of amenorrhoea and as a baseline in adolescents. The recommendation is for two-yearly scans thereafter while the DEXA scans are abnormal.
Other investigations may be indicated in certain clinical presentations to exclude other differential diagnoses (e.g. coeliac autoantibodies). Refer to CEED Medical Monitoring in Eating Disorders Summary Chart.

Clinical assessments forms

The InsideOut Institute has a number of clinical assessments available for use to assess patients who may have an eating disorder. These assessments include:

1. medical history taking for patients with an eating disorder
2. mental health assessment
3. nutritional assessment.

Activity 3.2 – Checklist to review access to assessment tools

Complete the checklist below to review your practice's access to assessment tools.

Questions to consider	Status	Action to be taken
Do all relevant team members understand the assessments and investigations to identify and manage eating disorder?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Information can be obtained from RACGP guidelines. How will this information be made available to all team members?
Do relevant team members have access to eating disorder assessments?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Refer to assessments available from InsideOut. How will this information be made available to all team members?
After reviewing your practice's access to assessment tools, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 3.2:

Practice name:	Date:
Team member:	

Activity 4 – Medicare item numbers and eating disorders

Changes introduced by the Australian Government on 1 November 2019 mean that some people with eating disorders will have access to an evidence-based, best-practice model of treatment. This will be known as an Eating Disorder Plan (EDP) and involves Medicare subsidies for 20 sessions with a dietitian and up to 40 sessions with a mental health clinician over a 12-month period.

The National Eating Disorders Collaboration has developed a cheat sheet for GPs to assist with navigating the new item numbers.

New MBS Items for Eating Disorders – Cheat Sheet for GPs

Item numbers for General Practitioners, available from 1 November 2019

Item numbers	MHST or Credentialed	Duration	Benefit 100%	Plan details
90250	NO	20-39 min	72.85	Written ED Tx and Mx plan which includes: a. Diagnosis b. Tx options and recommendations for the 12 months c. Outline referral options to AHP for mental health and dietetic services, specialists, etc *(referred clinicians must be eligible to provide MBS services under Better Access for psychological treatment or Chronic Disease Management for dietetic services)* d. Offer the patient & patient's carer (if any and if deemed appropriate with patient consent) a copy of plan and ED education
90251	NO	40 min and above	107.25	
90252	YES – MHST	20-39 min	92.50	
90253	YES – MHST	40min and above	136.25	
90264	Not specified	Not specified	72.85	Review ED TX and MX plan a. Treatment efficacy and evaluate with patient if it meets their needs b. Modifications to continue with Tx options in the plan or Alter treatment options in the plan with new arrangements c. Initiate referrals to psychiatrist or paediatrics as appropriate d. Offer the patient & patient's carer (if any and if deemed appropriate with patient consent) a copy of plan and ED education
90271	YES - FPS (in Consulting room)	30-39min	94.25	GP providing psychological services indicated in ED Tx and Mx plan. Specified evidence-based modalities: – Family Based Treatment for Eating Disorders (EDs) – Adolescent Focused Therapy for EDs – Cognitive Behavioural Therapy (CBT) for EDs (CBT-ED) – CBT-Anorexia Nervosa (CBT-AN) – CBT for Bulimia Nervosa and Binge Eating Disorder (CBT-BN, CBT-BED) – Specialist Supportive Clinical Management (SSCM) for EDs – Maudsley Model of Anorexia Treatment in Adults (MANTRA) – Interpersonal Therapy (IPT) for BN, BED – Dialectical Behavioural Therapy (DBT) for BN, BED – Focal psychodynamic therapy for EDs
90272	YES - FPS (out of consulting room, i.e. group session)	30-39 min	90271 Plus $26.35/Pt number seen up to 6 pts.	
90273	YES - FPS (in Consulting room)	40 min and above	134.85	
90274	YES - FPS (out of consulting room, i.e. group session)	40 min and above	90273 Plus $26.35/Pt number seen up to 6 pts.	
90279	FPS via video conference	30-39 min	$94.25	
90280	FPS via video conference	40 min and above	$134.85	

Prepared by the National Eating Disorders Collaboration in partnership with General Practitioners Dr Aline Smith and Dr Jenny Conway, for presentation at the GP19 and RMA19 conferences, 26 October 2019

New MBS Items for Eating Disorders – Cheat Sheet for GPs

Patient eligibility and assessment

There are two cohorts of eligible patients:

a. Patients with a clinical diagnosis of anorexia nervosa; or

b. Patients who meet the eligibility criteria (below), and have a clinical diagnosis of any of the following conditions:

- bulimia nervosa;
- binge-eating disorder;
- other specified feeding or eating disorder.

The eligibility criteria, for a patient from cohort b, is:

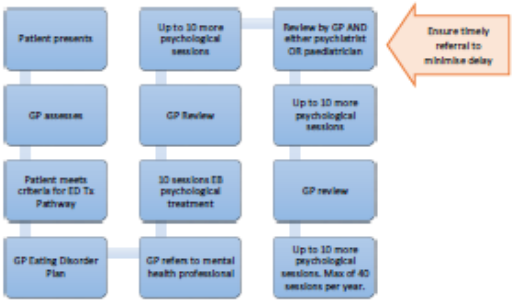
- a person who has been assessed as having an Eating Disorder Examination Questionnaire (EDE-Q) score of 3 or more; and
- the condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week; and
- a person who has at least two of the following indicators:
  - clinically underweight with a body weight <85% of expected weight where weight loss is directly attributable to the eating disorder;
  - current or high risk of medical complications due to eating disorder behaviours and symptoms;
  - serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function;
  - the person has been admitted to a hospital for an eating disorder in the previous 12 months;
  - inadequate treatment response to evidence based eating disorder treatment over the past six months despite active and consistent participation.

Practitioners should have regard to the relevant diagnostic criteria set out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

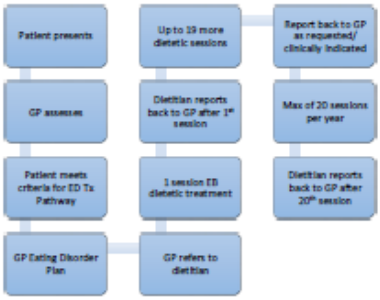
Practitioners can access the Eating Disorder Examination Questionnaire (EDE-Q) at https://www.credo-oxford.com/pdfs/EDE-Q_6.0.pdf

Pathways through treatment

- **Psychological Treatment**



- **Dietetic Services**



For any Eating Disorder patient not meeting criteria for the ED Treatment Pathway, Better Access and Enhanced Primary Care Plans should be used.

Prepared by the National Eating Disorders Collaboration in partnership with General Practitioners Dr Aline Smith and Dr Jenny Conway, for presentation at the GP19 and RMA19 conferences, 26 October 2019

Temporary eating disorder telehealth item numbers

During the COVID-19 outbreak, the Australian Government has provided temporary item numbers to manage patients with eating disorders. These numbers are available from March 2020 to September 2020. More information is available on the MBS fact sheet.

Service	Existing Items *face to face*	Telehealth items *via video-conference*	Telephone items *– for when video-conferencing is not available*
GP without mental health training, prepare an eating disorder treatment and management plan, more than 40 minutes	90251	92147	92155
GP with mental health training, prepare an eating disorder treatment and management plan, 20 to 40 minutes	90252	92148	92156
GP with mental health training, prepare an eating disorder treatment and management plan, more than 40 minutes	90253	92149	92157
GP to review an eating disorder plan	90264	92170	92176
GP eating disorder FPS treatment, 30 to 40 minutes	90271	92182	92194
GP eating disorder FPS treatment, more than 40 minutes	90273	92184	92196

Who is eligible for an eating disorder plan?

According to the Medicare Benefit Schedule, these are the eligible patients:

1. patients with a clinical diagnosis of anorexia nervosa; **or**
2. patients who meet the eligibility criteria (below), and have a clinical diagnosis of any of the following conditions:
    - bulimia nervosa
    - binge-eating disorder
    - other specified feeding or eating disorder

The eligibility criteria are:

a) a person who has been assessed as having an Eating Disorder Examination Questionnaire score of 3 or more

and

b) the condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour (intentional attempt to negate kilojoules consumed) as manifested by 3 or more occurrences per week

and

c) a person who has **at least two** of the following indicators:
    - clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder
    - current or high risk of medical complications due to eating disorder behaviours and symptoms
    - serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function
    - the person has been admitted to a hospital for an eating disorder in the previous 12 months
    - inadequate treatment response to evidence-based eating disorder treatment over the past six months, despite active and consistent participation

Practitioners should have regard to the relevant diagnostic criteria set out in the (DSM-5)

What are the benefits of completing an eating disorder plan?

Patients with an eating disorder treatment and management plan (EDP) will be eligible for comprehensive treatment and management services for a 12-month period, including:

- up to 40 eating disorder psychological treatment services (EDPT services)
- up to 20 dietetic services
- review and ongoing management services to ensure that the patient accesses the appropriate level of intervention

Consider treatment pathways under mental health treatment plans, and chronic disease management plans for patients who are not eligible for an eating disorder plan.

Eating disorders items stepped model of care

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders that comprise:

1. Planning

An eligible patient receives an eating disorder plan (EDP) developed by a medical practitioner in general practice, psychiatry or paediatrics.

2. Commence initial course of treatment (psychological & dietetic services)

Once an eligible patient has an EDP in place, the 12-month period commences and the patient is eligible for an initial course of treatment of up to 20 dietetic services and 10 eating disorder psychological treatment (EDPT) services. A patient will be eligible for an additional 30 EDPT services in the 12-month period, subject to reviews from medical practitioners to determine appropriate intensity of treatment.

3. Continue initial course of treatment

It is expected that the managing practitioner will review the patient on a regular, ongoing and as-required basis. However, a patient must have a review of the EDP, to assess the patient's progress against the EDP or update the EDP, before they can access more than 10 EDPT services.

4. Formal specialist and practitioner review

A patient must have two additional reviews before they can access more than 20 EDPT services. One review must be performed by a medical practitioner in general practice, and the other must be performed by a paediatrician or psychiatrist. Should both recommend the patient requires more intensive treatment, the patient would be able to access an additional 10 EDPT services in the 12-month period. These reviews are required to determine that the patient has not responded to treatment at the lower intensity levels.

5. Access to maximum intensity of treatment

To access more than 30 EDPT treatment services in the 12-month period, patients are required to have an additional review to ensure the highest intensity of treatment is appropriate. Subject to this review, a patient could access the maximum of 40 EDPT treatment services in a 12-month period. The fourth review should be provided by the patient's managing practitioner, where possible.

More information can be found at MBS Online. The full outline of the requirements for each item as well as the Stepped Model process can be found in the Eating Disorders Items Stepped Model of Care Quick Reference Guide.

Requirements of the eating disorder plan

The following information is required for the preparation of a written eating disorder treatment and management plan for an eligible patient:

- an opinion on the diagnosis of the patient's eating disorder
- treatment options and recommendations to manage the patient's condition for the following 12 months
- support options for parents/carers
- an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate.

The general practitioner should offer the patient and the patient's carer (if any) a copy of the plan and suitable education about the eating disorder.

What are the provider eligibility requirements?

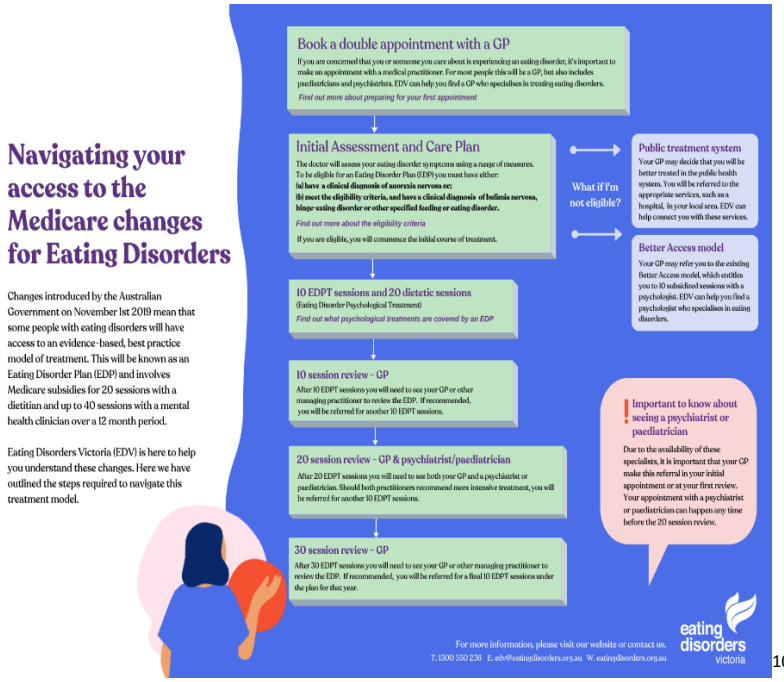
It is expected that practitioners who are providing services under these items have appropriate training, skills and experience in treatment of patients with eating disorders and meet the national workforce core competencies for the safe and effective identification of and response to eating disorders. More information can be found on NEDC National Practice Standards for eating disorders.

The following organisations provide training which may assist practitioners to meet eating disorder workforce competency standards:

- The Australia and New Zealand Academy of eating disorders (ANZAED) – National
- National Eating Disorders Collaboration (NEDC) - National
- InsideOut Institute - National
- The Victorian Centre of Excellence in Eating Disorders (CEED) - VIC
- Queensland Eating Disorder Service (QuEDS) - QLD
- Statewide Eating Disorder Service (SEDS) - SA
- WA Eating Disorders Outreach & Consultation Service (WAEDOCS) – WA

Navigating the eating disorders Medicare item numbers

Eating Disorders Victoria has created a flow chart to assist patients with navigating their way through the Medicare item numbers. You or your patient can download the resource from EDV.



[10]

Templates for completing an eating disorder plan

The InsideOut Institute have access to an eating disorder plan template and a GP care plan review template that can be imported into your clinical software program as a template.

[10] https://www.eatingdisorders.org.au/find-support/eating-disorder-medicare-changes/

Activity 4.1 – Eligibility for completing an eating disorder plan

Complete the checklist below to review your practice's ability to complete eating disorder plans.

Description	Status	Action to be taken
Do you have any GPs in your practice who have a special interest or have done extra training in managing people with eating disorders?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	List GPs who have extra training in managing people with an eating disorder: _____ _____ _____ _____
Do you have any GPs in your practice who are interested in pursuing further training or professional development in this area?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Refer to training options.
After reviewing your practice's eligibility to complete eating disorder plans, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 4.1:

Practice name:	Date:
Team member:	

Managing patients who do not meet the eating disorder plan criteria

If a patient does not meet the MBS criteria for an eating disorder plan, they may be eligible for a mental health treatment plan or chronic disease management plan.

Mental health treatment plan

There are a number of Medicare item numbers available for GPs to claim for mental health related consultations. Always refer to the Medicare Benefit Schedule for full details. The item numbers include:

Item description	Medicare criteria	Frequency of claiming
Mental Health Consultation (MBS item 2713)	Mental health consultation lasting at least 20 minutes. To claim this, the patient does not need to be on a mental health plan	No limits to the amount of times this item number is claimed
Mental Health Plan MBS Items 2700, 2701, 2715 or 2717)	A mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities The Mental Health Plan must include documenting the (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan	A new plan may be completed after 12 months if clinically required and if the person meets eligibility criteria. Full details of the criteria can be found here After plan has been completed, the patient is entitled to up to 10 Medicare subsidised visits with a Psychologist per calendar year. Full details of the criteria can be found here
Review Mental Health Plan (MBS item 2712)	The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation. A patient's GP Mental Health Treatment Plan should be reviewed at least once.	Can be claimed every three months or at least four weeks after claiming the Mental Health Plan item number.

More information about item numbers is available at Education guide for Mental Health Care

Chronic disease management plans

Holistic team-based care of both physical and mental health is critical to achieve the best possible outcomes for people living with both mental illness and chronic physical disease.

There are two types of plans that can be prepared by the patient's regular General Practitioner (GP) for Chronic Disease Management (CDM): GP Management Plans (GPMP MBS item 721); and Team Care Arrangements (TCAs MBS item 723).

Mental health and chronic disease plans for the same patient

The Chronic Disease Management (CDM) Medicare items continue to be available for patients with chronic medical conditions, including patients needing multidisciplinary care.

Patients with a mental illness only, who require a treatment plan to be prepared, should be managed under the GP Mental Health Treatment items (MBS items 2700, 2701, 2712, 2713, 2715 and 2717).

Where a patient has a mental illness as well as significant co-morbidities and complex needs requiring team-based care, the GP is able use both the CDM items (for team-based care) and the GP Mental Health Treatment items.[11]

Please note: GPs should always ensure they fully understand the criteria from Medicare before claiming the item number.

Activity 4.2 – Data Collection from your practice administration software

The aim of this activity is to review your practices claiming of MBS item numbers for patients with an eating disorder.

Complete the below table by collecting data from your practice administration software.

Note - Instructions on how to extract the data is available from Pracsoft or Best Practice.

	Description	Number of eligible patients	Number of MBS items claimed
4.2a	Number of patients with an eating disorder (from activity 1.1c, 1.1d & 1.1e) and an eating disorder plan claimed in the past 12 months		
4.2b	Number of patients with an eating disorder (from activity 1.1c, 1.1d & 1.1e) and an MH consult claimed in the past 12 months		
4.2c	Number of patients with an eating disorder (from activity 1.1c, 1.1d & 1.1e) and an MH treatment plan claimed in the past 12 months		
4.2d	Number of patients with an eating disorder (from activity 1.1c, 1.1d & 1.1e) who have had a GP management plan completed in the past 12 months		

[11] https://www1.health.gov.au/internet/main/publishing.nsf/Content/pacd-gp-mental-health-care-pdf-qa#7_1

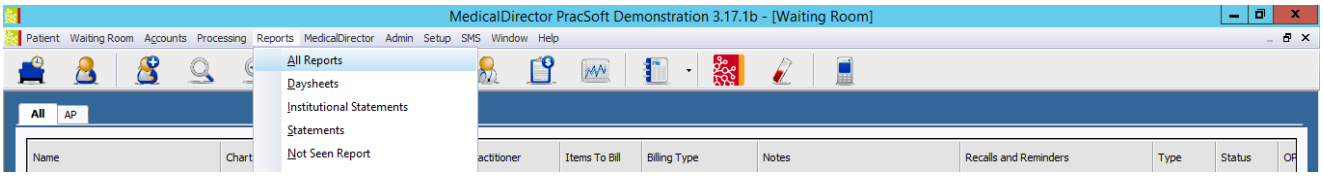
Reflection on Activity 4.2:

Practice name:	Date:
Team member:	

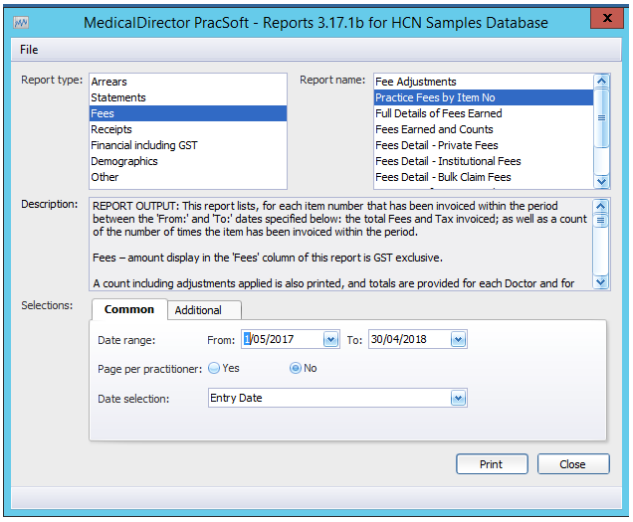
Instructions - Identifying the number of MBS numbers claimed in Pracsoft

To access the reports in Pracsoft:

1. From the main menu select **Reports** and **All reports**



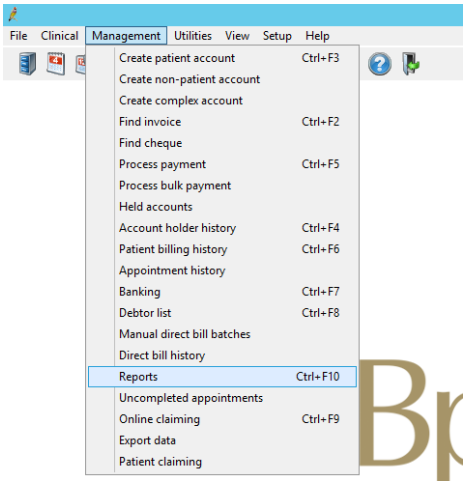
2. This will open up the **Report screen**:
3. Select **Fees, Report name: Practice fees** by item no, date range change to previous 12 months, page per practitioner select no and change the date selection to entry date.
4. Then click on the **Additional**
5. In the Item box, list all the eating disorder item numbers that are relevant to your practice with a comma separating each number
6. Select print and your report will appear on the screen.

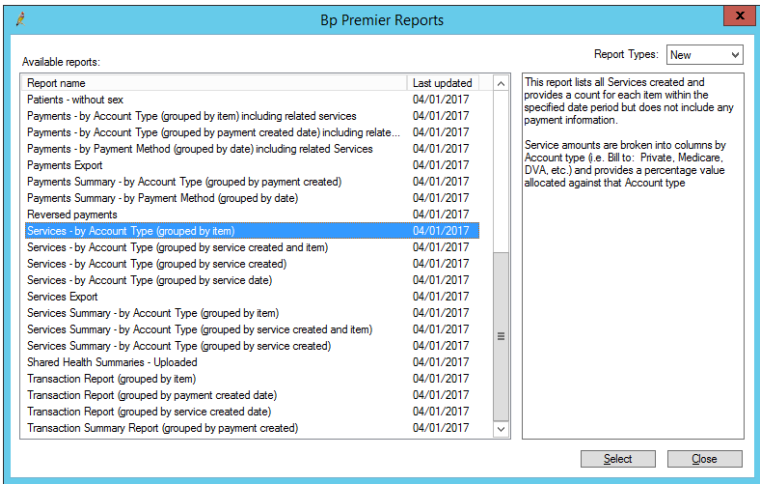


Instructions - Identifying the number of MBS item numbers claimed in Best Practice

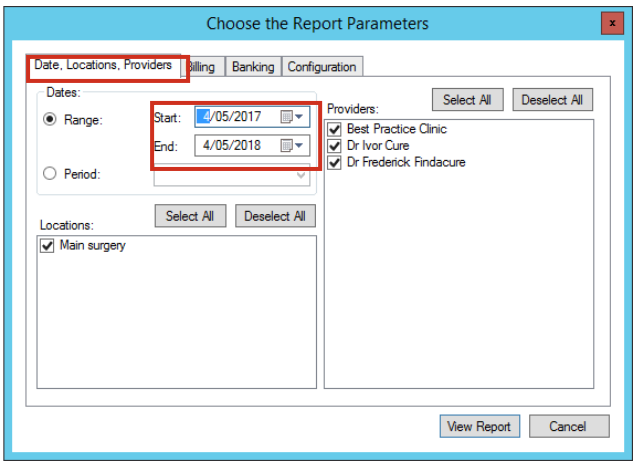
To access the reports in Best Practice:

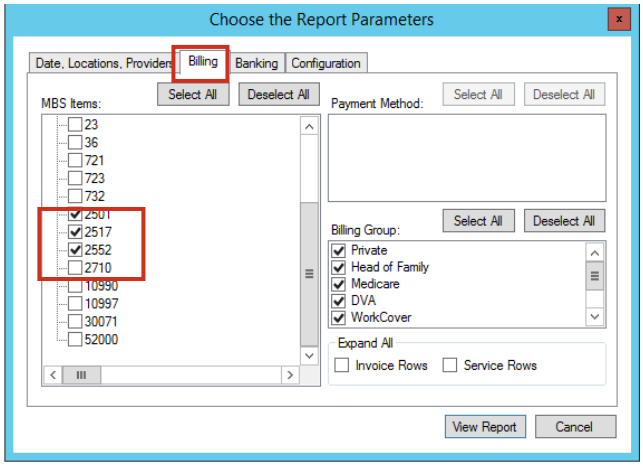
1. From the main screen, select **management and reports**



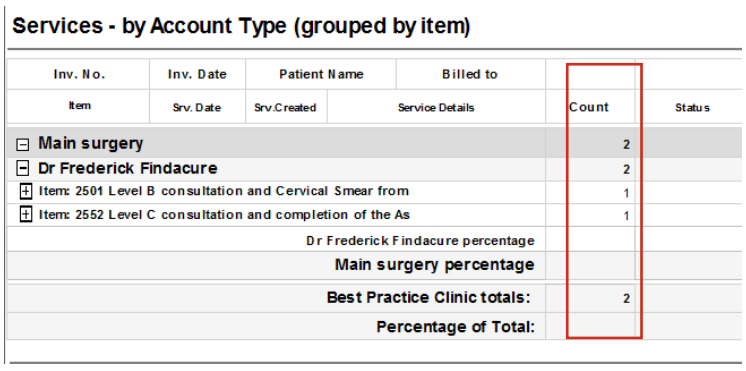


2. This will open up the report screen
3. Select **services – by account type** (group by item)
4. Select your date range to the previous 12 months under the **Date, Locations and Providers** tab
5. Click on the **Billing tab** and select the item numbers you would like to include in your report. Please note: the item numbers are only shown on this list, if there has been a claim for them at your practice





6. Click on the **View** report button
7. The report will then show the count per item number by provider.



Services - by Account Type (grouped by item)

Inv. No.	Inv. Date	Patient Name	Billed to		
Item	Srv. Date	Srv.Created	Service Details	Count	Status
Main surgery				2	
Dr Frederick Findacure				2	
Item: 2501 Level B consultation and Cervical Smear from				1	
Item: 2552 Level C consultation and completion of the As				1	
			Dr Frederick Findacure percentage		
			Main surgery percentage		
			Best Practice Clinic totals:	2	
			Percentage of Total:		

Activity 4.3 – Checklist for reflection on MBS claiming

Complete the checklist below to review your practice's MBS claiming for patients with an eating disorder.

Description	Status	Action to be taken
After completing activity 4.2 are there any unexpected results with your practice's MBS claiming for eating disorders?	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take?
Are there any patients with an active eating disorder who have not had either an eating disorder treatment plan or a GP mental health plan or a GP management plan?	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take? How will you use this information to increase the number of plans completed on patients with an eating disorder?
Have you created a Topbar prompt on all patients with an eating disorder who may be eligible for an eating disorder plan?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	Follow the instructions to complete this.
Does the practice have a system for tracking Medicare item number claiming?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Do GPs have access to their day sheets to identify MBS item numbers claimed? Does the practice nurse check that any assessments completed have the correct billing? Are item numbers checked against appointment diary prior to batching?

Description	Status	Action to be taken
Do you know the contact details for any MBS related questions?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Email: askMBS@health.gov.au Provider Enquiry Line - 13 21 50
Do relevant staff know that Medicare provides online training modules?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	More information can be obtained from Medicare Australia e-learning modules.
After reviewing the MBS claiming for patients with an eating disorder, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 4.3:

Practice name:	Date:
Team member:	

Activity 5. Referral pathways – eating disorders

Eating disorders are associated with significant psychiatric and medical morbidity. Effective management requires close collaboration between clinicians working in psychiatric and medical settings. It is important that patients have access to the level of health service they require as determined by their medical and mental health needs. In practical terms this means that patients have a right to access medical and mental health services across the continuum of care including community, inpatient and specialist services.[12]

RANZCP clinical practice guidelines for the treatment of eating disorders 2014

The first priority in the management of a patient with an eating disorder is securing medical and psychiatric safety. It is prudent to remember that a patient's visible habitus is not a reliable indicator of their medical risk. For example, a patient can have a normal body mass index (BMI) but also have a potassium level of 2.5 mmol/L due to their purging behaviours. In addition, BMI may be normal, but the patient might be at risk because of rapid weight loss or, in children, there may be failure to gain weight. The criteria for admission to hospital are listed below.[13]

RANZCP clinical practice guidelines for the treatment of eating disorders 2014

	Psychiatric admission indicated*	Medical admission indicated†
Weight	Body mass index (BMI) <14 kg/m^2	BMI <12 kg/m^2
Rapid weight loss	1 kg per week over several weeks or grossly inadequate nutritional intake (<100 kcal daily) or continued weight loss despite community treatment	
Systolic blood pressure	<90 mmHg	<80 mmHg
Postural blood pressure	>10 mmHg drop with standing	>20 mmHg drop with standing
Heart rate		≤40 bpm or >120 bpm or postural tachycardia >20 bpm
Temperature	<35.5°C or cold/blue extremities	<35°C or cold/blue extremities
12-lead electrocardiogram		Any arrhythmia including QTc prolongation, non-specific ST or T-wave changes including inversion or biphasic waves
Blood sugar	Below normal range‡	<2.5 mmol/L
Sodium	<130 mmol/L‡	<125 mmol/L
Potassium	Below normal range‡	<3.0 mmol/L
Magnesium		Below normal range‡

[12] https://metronorth.health.qld.gov.au/rbwh/wp-content/uploads/sites/2/2017/07/guide-to-admission-and-inpatient-treatment-eating-disorder.pdf
[13] https://www.racgp.org.au/afp/2017/november/early-detection-of-eating-disorders/

	Psychiatric admission indicated*	Medical admission indicated†
Phosphate		Below normal range
Estimated glomerular filtration rate		<60 ml/min/1.73m2 or rapidly dropping (25% drop within a week)
Albumin	Below normal range	<30 g/L
Liver enzymes	Mildly elevated	Markedly elevated (AST and ALT >500)‡
Neutrophils	<1.5 × 10^9/L	<1.0 × 10^9/L
Risk assessment	Suicidal ideation Active self-harm Moderate to high agitation and distress	

**Patients who are not as unwell as indicated above may still require admission to a psychiatric or other inpatient facility. †Medical admission refers to admission to a medical ward, short-stay medical assessment unit or similar. ‡Please note, any biochemical abnormality that has not responded to adequate replacement within the first 24 hours of admission should be reviewed by a medical registrar urgently.*

ALT, alanine aminotransferase; AST, aspartate aminotransferase

Activity 5.1 – Checklist for admission for patients with an eating disorder

Complete the checklist below to review your practice's understanding of the recommendations for admission for patients with an eating disorder.

Questions to consider	Status	Action to be taken
Do all relevant team members know the guidelines for hospital admission for patients with eating disorders?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Guidelines and information can be obtained from: RANZCP, RACGP summary or Queensland Eating Disorders Service
Does your practice have policy/procedure for facilitating hospital admissions for patients with an eating disorder when required?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Update policy and procedure manual
After reviewing hospital admission guidelines for patients with an eating disorder, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 5.1:

Practice name:	Date:
Team member:	

SpotOnHealth HealthPathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral of more than 550 conditions.

SpotOnHealth HealthPathways boasts a range of benefits including:

- best available information on how to assess and manage common clinical conditions, including when and where to refer patients
- easy online access to clinical and patient resources for in-consult use, peer-reviewed and localised to our region
- being integrated, concise, and saving you time.

It is an initiative of Metro South Health and Brisbane South PHN, in partnership with Mater Health Services and Children's Health Queensland. For more information, visit the SpotOnHealth HealthPathways project site.

The resource is designed to be used at point of care, primarily by general practitioners. It is also available to specialists, nurses, allied health and other health professionals.
To access these resources, you will need to log in.

SpotOnHealth HealthPathways and Topbar

The Topbar app provides a simple one-click access to the HealthPathways website. Topbar will show the app name (default is HealthPathWays) on top of your screen

You can search for a particular topic in the top left corner and under each topic there is a range of information available that may include:

- information specific to Aboriginal & Torres Strait Islander people
- information specific to culturally and linguistically diverse communities
- assessment tools and pathways
- management steps according to the latest guidelines
- requests/referral pathways
- clinical resources
- patient information
- references

Activity 5.2 – Checklist for reflection on use of SpotOnHealth HealthPathways

Complete the checklist below to review your practice's use of SpotOnHealth HealthPathways.

Questions to consider	Status	Action to be taken
Do all GPs and Nurses have login details for SpotOnHealth HealthPathways?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	To obtain username and password email spotonhealth@health.qld.gov.au
Are all GPs and Nurses familiar with SpotOnHealth HealthPathways navigation and able to find and use the eating disorders pathway?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	If you require training, contact BSPHN Digital Health Team via email: ehealth@bsphn.org.au
Do all GPs and Nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Contact BSPHN Digital Health Team via email: ehealth@bsphn.org.au
After reviewing the practice usage of SpotOnHealth HealthPathways, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 5.2:

Practice name:	Date:
Team member:	

Activity 6 – Education and resources

Training for GPs

General Practitioners (GPs) are the first point of call for people who feel they or a loved one may have an eating disorder. However, eating disorders are extremely complex mental illnesses that require some level of specialist knowledge to ensure symptoms are not confused with other conditions.

There are a number of organisations where GPs can contact to complete training. Options include:

- The Australia and New Zealand Academy of eating disorders (ANZAED) – National
- National Eating Disorders Collaboration (NEDC) - National
- InsideOut Institute - National
- The Victorian Centre of Excellence in Eating Disorders (CEED) - VIC
- Queensland Eating Disorder Service (QuEDS) - QLD
- Statewide Eating Disorder Service (SEDS) - SA
- WA Eating Disorders Outreach & Consultation Service (WAEDOCS) – WA

RACGP online learning

General Practitioners registered with the Royal Australian College of General Practitioners have access to this accredited online training. Areas covered include:

- description of the spectrum of disordered eating behaviours and their consequences
- explanation of the factors that contribute to the development of eating disorders and how to use this knowledge to identify patients at higher risk
- discussion on how to improve early recognition of eating disorders through identification of disordered eating behaviours and screening tools
- suggestions on communication techniques that support patient engagement and disclosure of disordered eating
- brief outline of interventions and treatment options pathways.

Clinical guidelines

- The Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders
- The Royal Australian and New Zealand College of Psychiatrist referred patient assessment and management plan guidelines

Health professional resources

- Identification of eating disorders in general practice
- National Eating Disorders Collaboration Eating Disorders: a professional resource for general practitioners
- MBS – eating disorders factsheet
- Australian and New Zealand Academy for Eating Disorders (ANZAED)
- Queensland Eating Disorder Service
- Spotonhealth HealthPathways
- Eating Disorders Queensland
- Academy for Eating Disorders (USA) – medical care standards guide, multiple languages available

Patient resources

- National Eating Disorders Collaboration
- Butterfly Foundation
- Eating Disorders Queensland
- Eating Disorders Victoria
- Eating Disorders Families Australia
- Reach Out and Recover (ROAR)
- Feed Your Instinct – for parents or carers concerned about their child
- Stories from Experience (note that this may be an adjunct to therapy but is not a replacement for it)

Quality improvement activities using the model for improvement and PDSA

After completing any of the workbook activities above you may identify areas for improvement in the management of patients with an eating disorder. Follow these steps to conduct a Quality Improvement Activity using the model for improvement and PDSA. The model consists of two parts that are of equal importance.

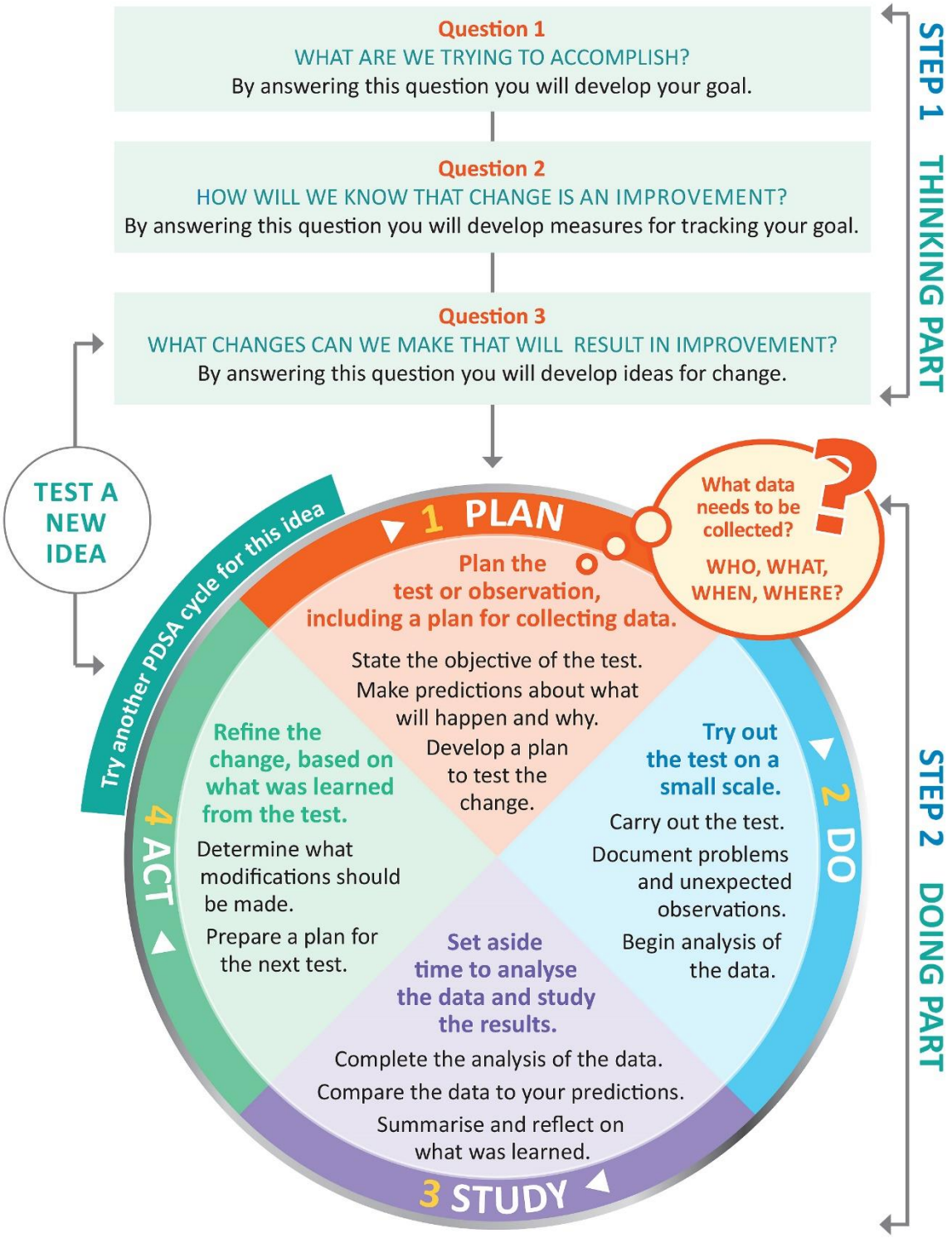
Step 1: The **'thinking'** part consists of three fundamental questions that are essential for guiding improvement work:

- What are we trying to accomplish?
- How will we know that the proposed change will be an improvement?
- What changes can we make that will lead to an improvement?

Step 2: The **'doing'** part is made up of Plan, Do, Study, Act (PDSA) cycles that will help to bring about rapid change:

- Helping you test the ideas.
- Helping you assess whether you are achieving your desired objectives.
- Enabling you to confirm which changes you want to adopt permanently.

The model for improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

Model for Improvement and PDSA worksheet EXAMPLE

Step 1: The Thinking Part - the 3 Fundamental Questions

Practice name:	**Date:**
Team member:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your goal for improvement.

Our goal is to:

- Increase the percentage of people with an active eating disorder who have an eating disorder plan.

This is a good start, but how will you measure whether you have achieved this goal?
The team will be more likely to embrace change if the goal is more specific and has a time limit.
So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to: Increase the percentage of people with an active eating disorder who have an eating disorder plan by 10% by 14 Feb.

Q2. How will you know that a change is an improvement? (Measure)

By answering this question, you will develop MEASURES to track the achievement of your goal.
E.g. Track baseline measurement and compare results at the end of the improvement.

We will measure the percentage of active patients with an eating disorder with an eating disorder plan.

To do this we will:

A) Identify the number of active patients with an eating disorder

B) Identify the number of active patients with an eating disorder who have an eating disorder plan

B divided by A x 100 produces the percentage of patients with an active eating disorder plan recorded

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.
You may wish to BRAINSTORM ideas with members of our practice team.

Our ideas for change:

1. Using CAT4, identify active patients with an eating disorder and identify those without an eating disorder plan.
2. Identify patients from the list exported from CAT4 and ensure Topbar prompts are working.
3. Encourage all GPs to participate in eating disorder education.
4. Ensure the whole of practice team are aware of the goal and identify ways to increase the number of plans completed.

The team selects one idea to begin testing with a PDSA cycle.

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement Guide
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. and Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

Model for Improvement and PDSA worksheet EXAMPLE

Step 2: The Doing Part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data.	What exactly will you do? Include what, who, when, where, predictions and data to be collected.
Idea: Using CAT4, identify active patients with an eating disorder and identify those without an eating disorder plan. This is going to be trialled with just one GP. **What:** Mary the receptionist will search patients on CAT4 and distribute lists to GP. **Who:** The GP will identify patients who would benefit from an eating disorder plan. Mary will then ensure a Topbar prompt is placed on identified patients. **When:** Begin 4 January. **Where:** At the practice. **Prediction:** 30% of the active patient population will an eating disorder will have an eating disorder plan. **Data to be collected:** Number of active patients with an eating disorder and number of active patients with an eating disorder and an eating disorder plan recorded.	
DO	**Who is going to do what? (Action)**
Run the test on a small scale	How will you measure the outcome of your change?
Completed 14 Feb – the receptionist contacted Brisbane South PHN for support with Topbar as she did not have access. The GP and receptionist worked well together to identify eligible patients to ensure eating disorder plans were initiated at the next visit.	
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions.	Was the plan executed successfully? Did you encounter any problems or difficulties?
The S.M.A.R.T. goal was to increase the number of eating disorder plans completed by 10%. The team actually got a 15% increase.	
ACT	**Do you need to make changes to your original plan? OR Did everything go well? (What next)**
Based on what you learned from the test, plan for your next step	If this idea was successful you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.
1. Using CAT4 generate list of patients with an eating disorder for ALL GPs in the practice. 2. Ensure the clinical team know how to complete eating disorder plans in the medical software. 3. Remind the whole team that this is an area of focus for the practice.	

Repeat Step 2 for other ideas – What idea will you test next?

Model for Improvement and PDSA worksheet template

Step 1: The Thinking Part - the 3 Fundamental Questions

Practice name:	Date:
Team member:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.

Q2. How will you know that a change is an improvement? (Measure)

By answering this question, you will develop MEASURES to track the achievement of your goal.

E.g. Track baseline measurement and compare results at the end of the improvement.

3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.

You may wish to BRAINSTORM ideas with members of our Practice Team.

Idea:

Idea:

Idea:

Idea:

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement plan.
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

Model for Improvement and PDSA worksheet template

Step 2: The Doing Part - Plan, Do, Study, Act cycle

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data.	*What exactly will you do? Include what, who, when, where, predictions and data to be collected.*
DO	**Who is going to do what? (Action)**
Run the test on a small scale.	*How will you measure the outcome of your change?*
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions.	*Was the plan executed successfully?* *Did you encounter any problems or difficulties?*
ACT	**Do you need to make changes to your original plan? (What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step.	*If this idea was successful you may like to implement this change on a larger scale or try something new.* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.*

Repeat Step 2 for other ideas - What idea will you test next?

First floor, Building 20, Garden City Office Park, 2404 Logan Road, Eight Mile Plains QLD 4113
PO Box 6435, Upper Mt Gravatt QLD 4122 T: 3864 7555 or 1300 467 265 | F: 3864 7599
bsphn.org.au | ABN 53 151 707 765

phn BRISBANE SOUTH
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