QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

Mental health

Eating disorders

MODULE

Version 3

October 2021

Introduction

The Quality Improvement (QI) toolkit

This 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 QI activities using the Model For Improvement (MFI).

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

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

The MFI 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 of improving the number of plans completed for people with an eating disorder using the MFI at the end of this module.

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

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP 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; MedicalDirector, 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.

While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage arising from the use of or reliance on the information provided herein.

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, 2021

Contents

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.

How to use this toolkit

There are checklists included below that will guide you and your practice to:

- Use this toolkit to guide you along the journey.
- Set yourselves timelines to achieve your goals.
- Consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season.
- Review your progress regularly.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support


support@bsphn.org.au


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Mental health – eating disorders

What is an eating disorder?

Eating disorders are serious, complex mental illnesses accompanied by physical and psychiatric complications which may be severe and life threatening. They are characterised by disturbances in behaviours, thoughts and feelings towards body weight/shape and/or food and eating.

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 behaviour (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. eating very slowly, insisting meals must always be at a certain time, inflexible use of crockery and cutlery, 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 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
- avoidance of eating meals by giving excuses (e.g. claiming they have already eaten or have an intolerance/allergy to particular foods)
- covert or secretive 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)
- changes in 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)

- 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, gain or fluctuation
- in children and adolescents, unexplained decrease in growth curve or body mass index (BMI) percentiles
- sensitivity to the cold (e.g. feeling cold most of the time, even in warm environments)
- delayed onset, loss or disturbance of menstrual periods
- reduced morning tumescence
- signs of frequent vomiting (e.g. swollen cheeks or jawline, calluses on knuckles, bad breath, damage to teeth)
- fainting, dizziness
- fatigue (e.g. 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
- lanugo – fine hairs covering the body and/or face
- cardio-respiratory complications (e.g. chest pain, heart palpitations, oedema, postural tachycardia, changes in blood pressure)
- low blood sugar
- osteoporosis or osteopenia
- 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:

- preoccupation with body shape, weight and appearance
- intense fear of gaining weight
- 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 or irritability around meal times
- depression or anxiety, non-suicidal self-injury or suicidality
- moodiness or irritability
- low self-esteem (e.g. feeling worthless, feelings of shame, guilt or self-loathing)
- rigid ‘black and white’ thinking (e.g. viewing everything as either ‘good’ or ‘bad’)
- feelings of being ‘out of control’

- using food as punishment (e.g. refusing to eat due to depression, stress or other emotional reasons)
- feelings of being unable to control behaviours around food[1].

Feed Your Instinct provides 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 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
- other specified feeding or eating disorder (OSFED)
- avoidant/restrictive food intake disorder (ARFID)
- pica
- rumination disorder
- 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.

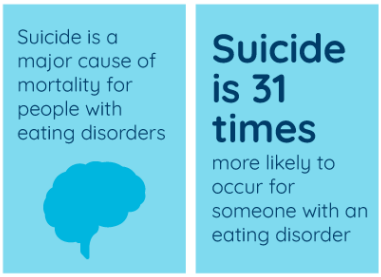
Impact of eating disorders

[2][3][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.[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. Training is available. This involves a comprehensive psychosocial assessment and assessment of suicidality.[6]



[1] https://www.eatingdisorders.org.au/eating-disorders-a-z/what-is-an-eating-disorder/
[2] https://www.nedc.com.au/assets/NEDC-Publications/National-Framework-An-integrated-Response-to-Complexity-2012-Final.pdf
[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://nedc.com.au/assets/NEDC-Resources/NEDC-Resource-Schools.pdf
[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 MedicalDirector *(search under conditions tab)*.

	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
1.1a	Number of active patient population		
1.1b	Number of patients with anorexia nervosa		
1.1c	Number of patients with bulimia or bulimia nervosa		
1.1d	Number of patients with an eating disorder		

Eating disorders and other mental illnesses

Eating disorders commonly occur with other mental illnesses including depression, anxiety, substance use disorders, and personality disorders. Research demonstrates that 55-97% of people diagnosed with an eating disorder also receive a diagnosis for at least one more psychiatric disorder.[7] 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 MedicalDirector *(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*)	

[7] Hudson JI, Hiripi E, Pope Jr HG, Kessler RC. The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biol Psychiatry. 2007;61(3):348-58

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 action 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?
After completing **activity 1.2**, are there any unexpected results with your practice's eating disorder and other mental illnesses profile?	☐ Yes: **see action 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 action to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 2 – Improving practice data measures

Guidelines to the safe collection of patient weight and height data

Weight, height and BMI 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, eating disorder 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 distressing experience 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 models which include viewed weighing as a form of exposure therapy and monitoring (e.g. Cognitive Behavioural Therapy for Eating Disorders (CBT-ED)),[8] 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.

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

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

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

	Description	Total number of active patients as per RACGP criteria (3 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 		

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 action 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?

Description	Status	Action to be taken
Do relevant team members know where to enter height, weight and BMI in your practice's software?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector. How will this information be communicated to the practice team?
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 action to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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. 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.

Activity 2.3 – Cleaning up un-coded conditions in your practice software

The aim of this activity is to identify and clean up any un-coded eating disorder conditions in your practice software.

Cleaning up un-coded items makes it easier to perform database searches and manage third-party clinical audit tools.

Identify

Follow the instructions for Best Practice or MedicalDirector to identify the number of un-coded eating disorders conditions.

Date data collected	Number of un-coded eating disorder conditions

What is a reasonable timeframe to complete this activity: _____

Who will be completing this activity: _____

Results

After you have actioned any un-coded eating disorder diagnosis, perform another database search in your practice software and record the number of un-coded conditions to track your results.

Date data collected	Number of un-coded eating disorders conditions

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 patient. 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 (MHR) 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 MHR if desired.

Activity 2.4 – 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
2.4a	Are all patients with an eating disorder coded correctly (*i.e. using the drop-down menus*) in your practice's clinical software program?	☐	☐	☐
2.4b	Has your practice determined terms of consistent coding?	☐	☐	☐
2.4c	Has your practice cleaned up any un-coded conditions?	☐	☐	☐
2.4d	Are all patients with an eating disorder marked as active or inactive?	☐	☐	☐
2.4e	Do you have a team member responsible for maintaining the practice database on a regular basis?	☐	☐	☐

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. [9]

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.

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 Eating Disorder Screen for Primary Care (ESP) is a useful screening tool in primary care settings.

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

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? [10]

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 activity. ☐ No, **see action 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 activity. ☐ No, **see action to be taken.**	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 action to be taken.** ☐ No, continue with 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 action to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Assessment of a patient with a suspected eating disorder

A thorough history will also eliminate many of the potential differential diagnoses. InsideOut have an eating disorder examination questionnaire EDE-Q available to assess eating disorder symptoms and behaviours and also is an essential component of the MBS EDP.

Physical examination and laboratory 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.[11]

[10] Cotton MA, Ball C, Robinson P. Four simple questions can help screen for eating disorders. J Gen Intern Med. 2003;18(1):53-6

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

Assessment of a patient with a suspected eating disorder

The initial physical assessment should include:

- measurement of height, weight, and body mass index (BMI) (adults); record weight, height and BMI percentile for age on growth charts (children and adolescents) (refer to Guidelines to the safe collection of patient weight and height data)
- sitting and orthostatic heart rate and blood pressure, with postural measurements
- body temperature
- assessment of breathing and breath (e.g. ketosis)
- examination of periphery for circulation and oedema
- assessment of skin, hair & nails (e.g. anaemia, carotenaemia, cyanosis, dry skin, brittle nails, lanugo, dorsal finger callouses/Russell's sign)
- hydration status (e.g. poor skin turgor, slow capillary return, moisture of mucosal membranes, tissue turgor)
- examination of head and neck (e.g. parotid swelling, dental erosions, gingivitis, conjunctival injection, pharyngeal red)
- gastrointestinal function (e.g. bloating, pain, constipation, diarrhoea)
- menstrual history (E.g. menarche, last menstrual period, regularity, oral contraceptive use, oral contraceptive use that may be masking the impact of eating disorder on menstrual status)

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
- 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:

- medical history taking for patients with an eating disorder
- mental health assessment
- 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 activity. ☐ No, **see action 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 activity. ☐ No, **see action 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 action to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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 is 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. There are also temporary telehealth item numbers available during COVID-19.

Item Number	Details	Time	Provider	Further Information
Preparation of eating disorder treatment and management plans				
90250	EDP preparation	At least 20 minutes but <40 minutes	GP without mental health training	The following information is required for the preparation of an EDP for an eligible patient: • Opinion on diagnosis • Treatment options and recommendations for management for 12 months • Outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate • Offer the patient and the patient's family/support (if any and if deemed appropriate with patient consent) a copy of plan and suitable eating disorder education
90251	EDP preparation	At least 40 minutes	GP without mental health training	
90252	EDP preparation	At least 20 minutes but <40 minutes	GP with mental health training	
90253	EDP preparation	At least 40 minutes	GP with mental health training	
Review of eating disorder treatment and management plans				

90264	EDR	-	GP	The following information is required for the review of an EDP:
				• Review the treatment efficacy of services provided under the EDP
				• Modifications made to the EDP and recorded in writing, including:
				  • recommendations to continue with treatment options detailed in the plan
				  or
				  • recommendations to alter the treatment options detailed in the plan, with the new arrangements documented
				• Initiate referral for review by psychiatrist or paediatrician, as appropriate
				• Offer the patient and the patient's family/support (if any and if deemed appropriate with patient consent) a copy of plan and suitable eating disorder education

Item Number	Details	Time	Provider	Further Information
GP provision of eating disorder psychological treatment services				
90271	EDPT in consulting rooms	At least 30 minutes but <40 minutes	GP with training in FPS	GPs providing eating disorder psychological treatment services initiated in the EDP. Specified evidence-based modalities include: • Family Based Treatment (FBT) for Eating Disorders • Adolescent Focused Therapy (AFT) for Eating Disorders • Cognitive Behaviour Therapy for Eating Disorders (CBT-E) • Cognitive Behaviour Therapy for Anorexia Nervosa (CBT-AN) • Cognitive Behaviour Therapy for Bulimia Nervosa and Binge Eating Disorder (CBT-BN or CBT-BED) • Specialist Supportive Clinical Management (SSCM) for Eating Disorders • Maudsley Model of Anorexia Treatment in Adults (MANTRA) • Interpersonal Therapy (IPT) for Bulimia Nervosa and Binge Eating Disorder • Dialectical Behaviour Therapy (DBT) for Bulimia Nervosa and Binge Eating Disorder • Focal Psychodynamic Therapy for Eating Disorders
90272	EDPT other than consulting rooms	At least 30 minutes but <40 minutes	GP with training in FPS	
90273	EDPT in consulting rooms	At least 40 minutes	GP with training in FPS	
90274	EDPT other than consulting rooms	At least 40 minutes	GP with training in FPS	
90279	EDPT by video conference	At least 30 minutes but <40 minutes	GP with training in FPS	
90280	EDPT by video conference	At least 40 minutes	GP with training in FPS	
92194	EDPT via telephone	At least 30 minutes but <40 minutes	GP with training in FPS	
92196	EDPT via telephone	At least 40 minutes	GP with training in FPS	

Flowchart for treatment under MBS EDP

Figure 1 outlines the pathway that a patient experiencing an eating disorder takes to access treatment under an EDP.

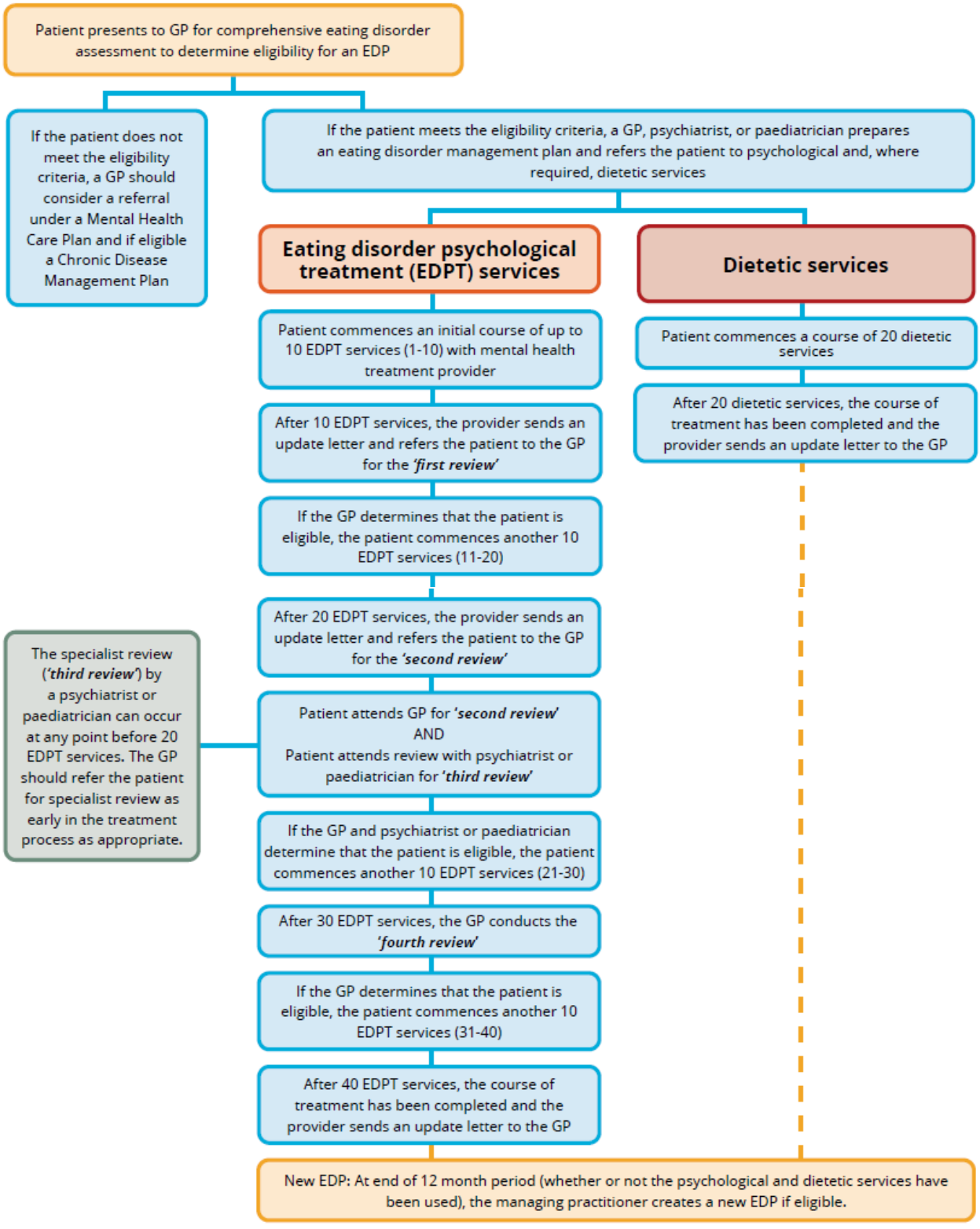


Figure 1 GP flowchart for treatment under MBS EDP

Who is eligible for an EDP?

According to the Medicare Benefit Schedule (MBS), 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 EDP?

Patients with an 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 EDP.

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 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 EDP

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?

According to the NEDC National Practice Standards for eating disorders, 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.

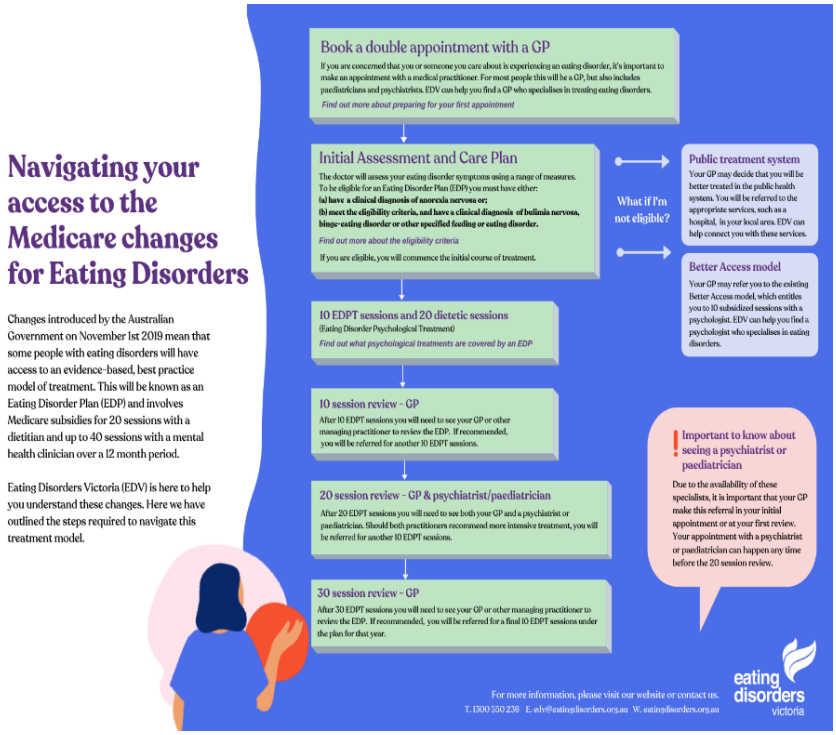
The following organisations provide training which may assist practitioners to meet eating disorder workforce competency standards:

- 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 MBS item numbers

Eating Disorders Victoria has created a flow chart to assist patients with navigating their way through the MBS item numbers. You or your patient can download the resource from EDV.[12]

NEDC also provides MBS information including management plan templates, understanding the criteria and support services.



Templates for completing an EDP

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

Managing patients who do not meet the EDP criteria

If a patient does not meet the MBS criteria for an EDP, they may be eligible for a mental health treatment plan and/or chronic disease management (CDM) plan.

The CDM MBS 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 GPMHTP 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 GPMHTP items.[13]

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

Mental Health Treatment Plan (MHTP)

There are several Medicare item numbers available for GPs to claim for mental health-related consultations, which include eating disorders not eligible for the EDP. After the assessment and planning, referral to a Medicare-registered mental health clinician for up to 10 Medicare-subsidised sessions per annum can occur. During 2021, patients may be eligible for an additional 10 Medicare subsidised sessions in response to the Covid-19 pandemic. Refer to information from MBS or factsheet.

A MHTP may also be considered as a support option for family to manage their own mental health needs.

[12] https://www.eatingdisorders.org.au/find-support/eating-disorder-medicare-changes/
[13] https://www1.health.gov.au/internet/main/publishing.nsf/Content/pacd-gp-mental-health-care-pdf-qa#7_1

Chronic Disease Management Plan (CDMP)

The CDMP Medicare items are for GPs to manage the health care of people with chronic or terminal medical conditions, including those requiring multidisciplinary, team-based care from a GP and at least two other health or care providers.

There are two types of CDMP plans that can be prepared for a patient by their GP:

- GP Management Plan (GPMP) - a person who has a chronic or terminal medical condition (with or without multidisciplinary care needs)
- Team Care Arrangement (TCA) - a person with a chronic or terminal medical condition and complex care needs, requiring care from a multidisciplinary team

The CDMP enables a GP to refer a patient for up to five individual allied health services per calendar year. The CDM may be suitable for disordered eating, sub-clinical eating disorder presentations or those not wishing to engage in active treatment for their eating. A patient's eligibility for a CDMP is a matter for the GP to determine. Refer to the MBS for full details.

Activity 4.1 – Eligibility for completing an EDP

Complete the checklist below to review your practice's ability to complete EDP.

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 action 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 action to be taken.** ☐ No: continue with activity.	Refer to training options.
Do all team members know where to access EDP templates?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to templates from InsideOut Institute for an EDP template or GP care plan review template.
After reviewing your practice's eligibility to complete EDPs, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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 EDP 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 GPMHTP 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 GPMP claimed in the past 12 months		

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.

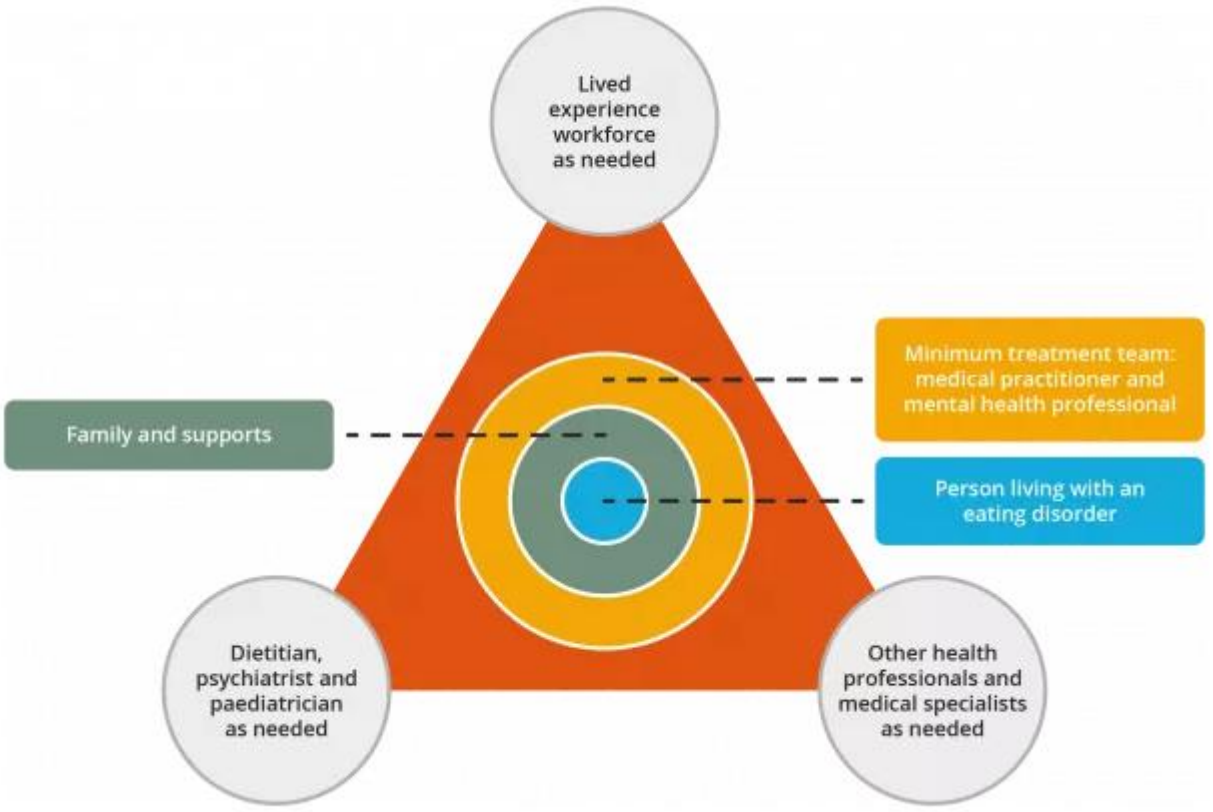
Description	Status	Action to be taken
After completing **activity 4.2** are there any unexpected results with your practice's MBS claiming for eating disorders?	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take?
Are there any patients with an active eating disorder who have not had either an EDP, GPMHTP or GPMP?	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take?

Description	Status	Action to be taken
		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 EDP?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Follow the instructions to complete this.
Do you know the contact details for any MBS related questions?	☐ Yes, continue with the activity. ☐ No, **see action 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 action 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 action to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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.[14]

NEDC provides more information on the importance of the care team for people living with an eating disorder.



[15]

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.[16]

[14] https://metronorth.health.qld.gov.au/rbwh/wp-content/uploads/sites/2/2017/07/guide-to-admission-and-inpatient-treatment-eating-disorder.pdf
[15] https://nedc.com.au/eating-disorders/treatment-and-recovery/the-care/
[16] https://www.racgp.org.au/afp/2017/november/early-detection-of-eating-disorders/

Table: Indicators for consideration for psychiatric and medical admission for adults

	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‡
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.

SpotOnHealth HealthPathways

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 activity. ☐ No, **see action 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 activity. ☐ No, **see action 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 action to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral of more than 500 conditions. It 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.

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.

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 activity. ☐ No, **see action to be taken.**	To register.

Questions to consider	Status	Action to be taken
Are all GPs and nurses familiar with SpotOnHealth HealthPathways navigation and able to find and use the eating disorders pathway?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	If you require training contact Metro South Health GPLO officer on (07) 3156-4346 or email Brisbane South PHN on support@bsphn.org.au.
Do all GPs and nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes, continue with activity. ☐ No, **see action 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 action to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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

NEDC – Eating Disorder Core Skills: eLearning for GPs

NEDC has developed Eating Disorder Core Skills: eLearning for GPs – comprehensive foundational eating disorder training developed specifically for GPs. The training provides GPs with the key information needed to provide best practice care for patients with eating disorders.

This freely accessible, four-hour, self-paced and interactive online training includes practical real-life scenarios and activities, videos from leaders in the field and people with a lived experience of an eating disorder, up-to-date resources and a formal assessment.

The training will equip GPs with the knowledge and skills needed to understand, identify and assess eating disorders, provide medical treatment, lead the multidisciplinary team, manage MBS items and provide ongoing recovery support.

Eating Disorder Core Skills: eLearning for GPs is accredited by the RACGP as a CPD Accredited Activity (40 points), the General Practice Mental Health Standards Collaboration (GPMHSC) as Mental Health CPD, and the Australian College of Rural and Remote Medicine (ACRRM) under the Professional Development Program

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
- ANZAED eating disorder treatment principles and general clinical practice and training standards
- NEDC National Practice Standards for eating disorders.

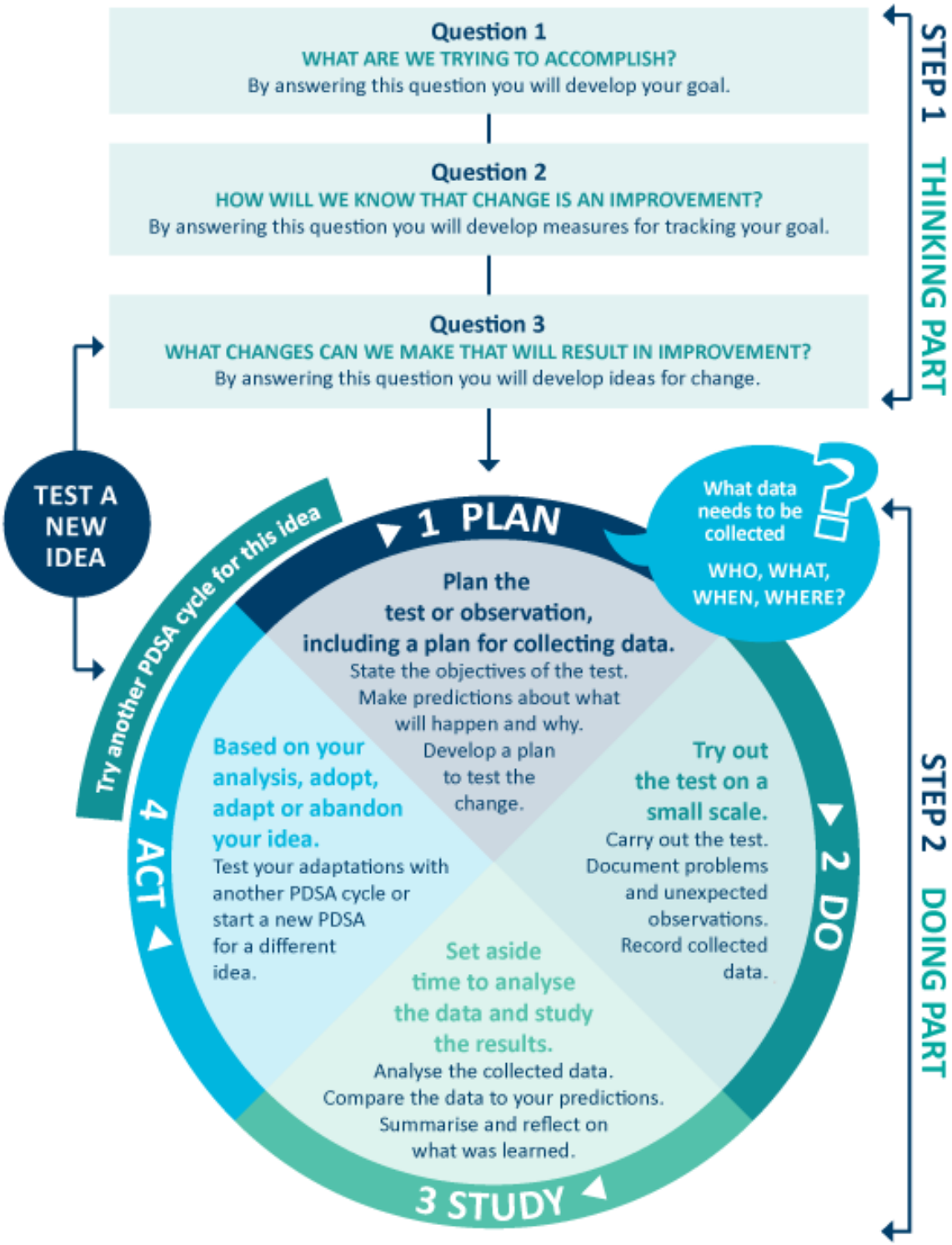
Health professional resources

- 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.

Lived experience resources

- National Eating Disorders Collaboration
- Butterfly Foundation
- InsideOut Institute
- 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).

Model for Improvement diagram



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

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	

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

By answering this question, you will develop your GOAL for improvement.
Record this as an S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

Our goal is to:

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

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 EDP by 10% by 14 Feb.

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

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc.). Record and track your baseline measurement to allow for later comparison.

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

B divided by A x 100 produces the percentage of patients with an active EDP recorded.

BASELINE MEASUREMENT: 17% of active patients with an eating disorder have an EDP.

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

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.MA.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Identify active patients with an eating disorder and identify those without an EDP.

IDEA: Create a Topbar prompt for eligible patients who do not have an EDP recorded.

IDEA: Encourage all GPs to participate in eating disorder education.

IDEA: Source and provide endorsed patient education resources (in waiting rooms, toilets etc.).

IDEA: Ensure the whole of practice team are aware of the goal and identify ways to increase the number of plans completed.

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA template

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Identify active patients with an eating disorder and identify those without an EDP.	

PLAN	Record the details of how you will test your change idea
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.
WHAT: Sally will conduct a search on CAT4 to identify active patients with an eating disorder. This report will be provided to Dr Brown who will identify patients eligible for an EDP. A Topbar prompt will be created for eligible patients and also a reminder added to the patient file to prompt the GP to discuss this at the next appointment. WHO/WHEN/WHERE: Who: Receptionist. When: Begin 4th January. Where: Dr Brown's office. DATA TO BE COLLECTED: Number of active patients with an eating disorder and the number of active patients with an eating disorder and an EDP recorded.	

DO	Run the test, then record your actions, observations and data
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).
Done – completed 14th February – Sally conducted a search on CAT4 and identified patients with an eating disorder. The list was then given to Dr Brown who identified patients who would benefit from an EDP. Sally then created a Topbar prompt to ensure the relevant team members were alerted to the missing EDP when the patient arrived for their next appointment. This was only conducted on Dr Brown's patients as a trial.	

STUDY	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.
At the end of the focus on EDP, we identified 30% of patients with an eating disorder had a plan implemented. This was a 13% increase. Results have been shared with the whole practice team. *Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.*	

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*

ADOPT:

ADAPT:

The practice will definitely adapt this method for other GPs in the practice. Dr Brown has successfully identified a model that will work for the practice.

ABANDON:

Repeat step 2 to re-test your adapted plan or to test a new change idea

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