



Eating Disorder Nutrition Data Reporting **Nutrition/ Health Management Committee**

The current treatment environment for those suffering with an eating disorder (ED) mandates acquisition and reporting of patient related information. This is not limited to the obvious diagnostic codes, laboratory data, or physical parameters of height, weight and body mass index (BMI). The goal is to quantify behaviors and symptoms/concerns using measurable data whenever possible.

This information is not intended to inhibit a professional from using interviewing skills to promote trust and effective communication within the therapeutic relationship. It is intended to promote quantifiable reporting to obtain not only maximum reimbursement for care but also improve standardization for the level of care recommendations.

Key data to collect and report:

1. Anthropometrics – as many of the following as are available: Current weight, lowest weight, highest weight, BMI, body fat percentage, recent weight change vs usual body weight, % weight loss, body composition by DEXA.
2. Specifics for children/teens- growth history, growth charts - especially those showing a decline or abnormal growth or weight changes, current weight as a % of goal weight, estimated calories for catch-up growth and physical activity, estimated calories to initiate or restore menses.
3. Lab data – any indications of malnutrition or inappropriate dietary intake, computerized nutrient assessment of food records for micronutrient evaluation.
4. Energy and macronutrient intake using comparison to goals or standards- % estimated daily needs, % of meals completed, % compliance with meal plan, % oral intake vs. tube feeding, % solid food intake vs. liquid nutritional supplement, specific deficit and recommended requirements if food intake is not adequate for calories expended or restoration of menses per care plan.
5. Fluid intake as % of estimated needs, fluid loading or effect of fluid intake/restriction on patient weight if applicable.
6. Recommended weight goal(s) including intermediate/short-term goal for each level of care and long-term/recovery goal if applicable.
7. Specific expectations for nutrition and/or weight until the next evaluation in the current level of care.

8. Compliance/non-compliance/abuse of medication including stimulants, OTC, laxatives, and diet pills using specific data regarding frequency, number of pills, etc. Continued documentation throughout treatment in comparison to initial reported use.
9. Eating behaviors and symptoms- # of daily episodes, # of days per week meeting or not meeting goals for reduced behaviors (ex: # of vomits per each purging episode), frequency of food rituals, anxiety reported or observed at meals, inability to complete meals, hiding of food, # of supplements required to make up calorie deficits, time spent on food preparation, direct patient quotes specific to the patient's eating disorder diagnosis and motivation toward recovery.
10. Direct meal exposure observations- pre, mid, and post meal anxiety, # of observed food rituals, required supplementation, timely completion, and improvement from last meal observed.
11. Recorded days of compliance- with meal plan, when recovery tools were used, number of days where "ED language" of food and weight improved or regressed.
12. Quantification of time in obsessive behaviors - around food preparation, counting of calories, use of apps or trackers, blogging about food, etc.
13. Improvement in ideas or thoughts -about food, nutrition, body image disturbance, movement towards reality vs fantasy.
14. Observations -"Client was observed to restrict at all meals by eating only 50% of her meal plan, consuming 1000 kcals as compared to her 2000 kcal prescribed meal plan", "Client states that during her dinner meal, 'My eating disorder was so loud every bite felt like torture. I don't know how I ate what I did.'"
15. Detailed intake of non-caloric food and beverage intake: gum chewing, water, coffee, diet soda, etc.
16. Evaluation of home environment- ability to support the care plan and nutritional goals, compliance with and ability to utilize suggested meal companions, parental monitoring of meals if an adolescent, training of social support persons.
17. Details on exercise - duration, frequency, intensity, signs of excessive physical activity or exercise addiction including ignoring work or family obligations, exercise performed against medical advice, refusal to rest, compliance/noncompliance with activity restriction.
18. Hunger and fullness, including fear food inventories.

19. Quantification of “layering” of behaviors – use of laxatives, exercise and/or self-induced vomiting, restricting, etc.
20. Primary issues requiring attention – top one or two issues in level of severity, areas of difficulty
21. Evidence for level of care with specific terminology – “Client continues to meet APA criteria for extended stay at _____ level of care as evidenced by his/her _____ (inability to complete meal plan goals for weight restoration, inability to go 24 hours without self-induced vomiting), even when utilizing _____ (medications, support, nutritional supplementation) provided by staff.”

As much as possible, compare patient’s current status to patient’s recovery goals.

**Nutrition/Health Management Committee
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