

Eating Disorders in Primary Care: A Novel Tool for Screening and Referral

Webinar Transcript

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la-shell_johnson@med.unc.edu: I'd like to welcome you all today to our webinar series. A few things to note, participants will be muted upon entry and videos turned off. For technical assistance, we ask that you please use the chat box located at the bottom of your screen.

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la-shell_johnson@med.unc.edu: I will now go ahead and introduce today's presenter. Our presenter today is Dr. Christine Peat. The Director of the National Center of Excellence for Eating Disorders, also known as NCEED and an Associate Professor of Psychiatry at the University of North Carolina at Chapel Hill.

la-shell_johnson@med.unc.edu: She completed her undergraduate training in psychology at the University of Arizona and earned her master's degree and doctorate in clinical psychology at the University of North Dakota.

la-shell_johnson@med.unc.edu: Her internship was in behavioral medicine at West Virginia University, after which she went on to complete her postdoctoral fellowship in eating disorders research at the University of North Carolina under the directorship of Dr. Cynthia Bulik.

la-shell_johnson@med.unc.edu: As the director of NCEED, Dr. Peat's focus is on broadly disseminating education and training on eating disorders to healthcare providers across a variety of disciplines.

la-shell_johnson@med.unc.edu: Her research centers on eating pathology across the spectrum, but with a distinct focus on binge-eating disorder. She's particularly interested in the intersection between

obesity, bariatric surgery, and eating pathology and investing physiological comorbidities associated with eating disorders.

la-shell_johnson@med.unc.edu: Dr. Peat is also a licensed psychologist in North Carolina, and, as such, treats eating disorders across the spectrum, where the primary focus is on binge eating. Given her background in behavioral medicine, she has also established clinical services in GI surgery, where she provides both psychotherapy and behavioral medicine interventions to this patient population.

la-shell_johnson@med.unc.edu: In addition to her clinical and research responsibilities, Dr. Peat is also a clinical supervisor for pre-doctoral psychology interns, psychiatry residents, and mentors undergraduate research students. I'll now turn things over to Dr. Christine Peat.

Christine Peat (she/her): Wonderful. Thank you so much La-Shell. Thanks everybody for being here this afternoon, or this morning, or this evening, depending on where you are in the world.

Christine Peat (she/her): As La-Shell indicated, I am Christine Peat. I'm the Director of NCEED, and I'm really thrilled to have you here with us today. We're going to talk a little bit about some of the work that we have been doing, in terms of developing a novel screening tool for use in primary care.

Christine Peat (she/her): And we'll talk a little bit about the protocol itself and then where we're headed down the road. And I'd love to hear any thoughts or comments or suggestions that you all have.

Christine Peat (she/her): As you learn more about this tool, given that we really want it to be something that's useful for the field and something that you know, the more feedback that we have the better. We believe that it will perform, so feel free to be using the chat box along the way to send questions over. And I know that there'll be time at the end and La-Shell will be helping to facilitate some of that question and answer session.

Christine Peat (she/her): Oh right so before we kind of dive into the main part of today's content, I just wanted to draw your attention to our website for those of you that may not have attended any of our webinars are maybe new to NCEED.

Christine Peat (she/her): Our website is down here at the bottom right of your screen and there's just a quick snapshot there of our homepage, really just kind of giving you an overview of what we provide in terms of the library of resources, the training page.

Christine Peat (she/her): We have different stakeholder groups that we know will be using our website, so there's information for healthcare providers, which of course would include mental health care providers like psychologists, counselors, in addition to our medical providers are physicians and nurses.

Christine Peat (she/her): And then we also have curated information for individuals with lived experience, in addition to family members and friends, so please feel free to make use of the website and all the resources that are there, everything is available free of charge.

Christine Peat (she/her): In terms of what we're going to talk about today there's just a brief roadmap. I'd like to kind of set the stage and describe eating disorder diagnoses and the overall burden.

Christine Peat (she/her): I know that many of you in here are familiar with eating disorders. This is your life's work, but I just want to make sure that for everyone who's in attendance, that we have a shared understanding what we're talking about when we refer to eating pathology.

Christine Peat (she/her): We'll also talk a little bit about identifying patients who might be at risk for under detection of eating disorders.

Christine Peat (she/her): And then finally, I'll be able to share with you a little bit about our protocol that we've developed for screening brief intervention and referral to treatment of eating disorders.

Christine Peat (she/her): Many of you are probably familiar with some of the information on the next couple of screens. But for those of you who are not, there was a report that was done and I believe it was in July of 2020, in collaboration with Deloitte Economics, Striped, which is a public health group out of Harvard, and also the Academy for Eating Disorders, to really look at the social and economic burden of eating disorders in the US.

Christine Peat (she/her): And so what I'd like to draw your attention to, here are some general statistics that I think will be important as we're thinking about setting the stage for today's talk.

Christine Peat (she/her): So what this report found was that roughly 28 million Americans will struggle with an eating disorder at some point in their lifetime. So we're talking about roughly 9% of the US population.

Christine Peat (she/her): And I think that this is a statistic that even though many of us might work in eating disorders are still kind of surprised by, given that oftentimes there's this narrative out there that

eating disorders are rare kind of niche conditions that most people will grow out of, if it's a phase those sorts of things.

Christine Peat (she/her): But really we're talking about a fairly significant population of the US and that these are particularly serious illnesses. And, in fact, it was estimated that there would be over 10,000 deaths per year, as a direct result of an eating disorder. Such that one person will die every 52 minutes as a result of their condition.

Christine Peat (she/her): One of the important points that will spend some time talking about today, too, is that eating disorders do affect everyone.

Christine Peat (she/her): We know that there are rampant stereotypes about eating disorders, but we know that at this point, based on the research that's been done that eating disorders don't discriminate based on your age, your race, your gender, or sexual orientation. And so, it's really important for us to be thinking about all the people who are, who might fall outside of that traditional stereotype of an eating disorder.

Christine Peat (she/her): In terms of the overall cost to society, we know that eating disorders cost somewhere around \$64 billion per year, in terms of things like direct patient care lost to economic productivity, all kinds of different costs that you can see, broken down here.

Christine Peat (she/her): For those of you that are interested, there's also state-by-state information from the Deloitte report. So, if you're wondering about what kinds of prevalence estimates, for what kinds of costs might be going on in your particular state, you can find that information online. I'll make sure that gets sent around as well in addition to the slides. So again, this is just kind of setting the stage for what we're talking about and we refer to as eating disorders, how pervasive they might be; at how much of a problem that they are both in terms of the human cost, but also the economic cost.

Christine Peat (she/her): When we're talking about eating disorder diagnoses, there are a number of different things that I'm sure you all are familiar with.

Christine Peat (she/her): But I wanted to talk a little bit about some specifics, so that we can kind of be thinking about these diagnoses as we move through the talk.

Christine Peat (she/her): So, the first diagnosis I'm going to start with somewhat atypically is Other Specified Feeding and Eating Disorder. And, I'm starting with this diagnosis intentionally. So, for those of you that are routinely work with eating disorders, it will come as no surprise that this is actually the most common eating disorder diagnosis.

Christine Peat (she/her): For those of you who may be less familiar when we're talking about this OSFED condition. Are really talking about eating disorder symptoms, eating disorder behaviors, thoughts that don't necessarily meet every single diagnostic criteria. So let's say Anorexia Nervosa or Bulimia Nervosa.

Christine Peat (she/her): We can kind of largely conceptualize this as kind of that spectrum of eating pathology, where someone may not meet every single frequency criteria and/or meet every single diagnostic criteria, but they still are struggling in some way with their relationship with food their relationship with their body.

Christine Peat (she/her): Part of the reason that I'm highlighting this here is that, given that we're going to be talking about a primary care screening tool; I think it's important that, that's kind of the mindset that we have we're thinking about screening for eating disorders.

Christine Peat (she/her): We're not necessarily screening for individuals who have very obvious signs or symptoms of an eating disorder, or who may come to us explicitly knowing that they've been diagnosed with an eating disorder.

Christine Peat (she/her): Many people that we are really trying to screen in primary care, may lack some of these obvious signs, and may end up falling into this kind of OSFED category.

Christine Peat (she/her): The other diagnoses, are ones that many of you are probably familiar with things like anorexia nervosa where the defining feature is this intense fear of gaining weight.

Christine Peat (she/her): So that's, that to the individual is restricting their energy intake, to the point where they're losing a significant amount of weight or they're engaging in behaviors that interfere with weight gain. I think this is a very common diagnosis that many of you are familiar with in you know pop up you know.

Christine Peat (she/her): In a larger cultural circles just things to be aware of in terms of. You know, low body weight preoccupation with food, eating, and calories. We can talk more about the nuances of these diagnoses in the question and answer session. I'm happy to do that, but for the purposes of today's talk I'll just keep moving through.

Christine Peat (she/her): Bulimia nervosa is another eating disorder diagnosis. It's characterized by binge-eating episodes and then paired with what we would call these inappropriate compensatory behaviors. So, these are going to be things like self-induced vomiting, compulsive driven exercise, laxative abuse, diuretic abuse, and usually there temporarily paired such that someone's having a binge eating episode very closely followed by one of these kinds of compensatory behaviors.

Christine Peat (she/her): Binge-eating disorder is very similar to bulimia nervosa in that both are characterized by binge eating episodes. But for this particular diagnosis, diagnosed individuals are not engaging in those compensatory behaviors on a regular basis.

Christine Peat (she/her): So, these are folks that are having recurrent binge eating episodes where they feel out of control. They might be eating large volumes of food feeling guilty ashamed, or disgusted with themselves afterwards.

Christine Peat (she/her): And then avoidant restrictive food intake disorder is an eating disorder diagnosis that's characterized by a persistent failure to meet nutritional or energy needs, based on your age developmental stage.

Christine Peat (she/her): And you might be thinking that this sounds very similar to anorexia nervosa. But this is actually a condition in which someone does not have that same sort of drive for thinness, or a drive for weight loss, or your weight gain. These are individuals that may not might not be meeting their nutritional goals because of sensory characteristics with food, or aversive experiences with food that have led to some degree of anxiety around eating

Christine Peat (she/her): So there are again some diagnostic nuances here that we can discuss. But, that's largely what we're talking about for today's purposes when we refer to eating disorder diagnoses.

Christine Peat (she/her): One of the things that I also do want to spend some time talking about is this misperception that there is a look for individuals that have an eating disorder. And, I think it's particularly important to be talking about that, when we're thinking about a primary care audience.

Christine Peat (she/her): So, I think oftentimes, we might be expecting that if someone has come in losing a certain amount of weight or someone who might fit a certain stereotype of eating disorders, whether that's a young, white, cisgender female.

Christine Peat (she/her): Then we might think of screening those individuals for an eating disorder. But we know that those are the stereotypes that are actually the most misleading, because eating pathology really is a spectrum and there isn't any particular look for someone with an eating disorder.

Christine Peat (she/her): In fact, we know that many individuals who are a part of a marginalized community may actually be at particular risk for an eating disorder.

Christine Peat (she/her): So individuals living in high, higher weight bodies, or larger bodies may not necessarily be screened for an eating disorder or even have that be a part of their differential diagnosis, because they don't fit that stereotype.

Christine Peat (she/her): But, any individual can struggle with an eating disorder, irrespective of the body weight, shape, or size. Individuals who come from racial or ethnic minorities may also not be routinely screened for eating disorders, but they certainly struggle with the full spectrum of eating pathology.

Christine Peat (she/her): And then individuals with food insecurity may also be struggling with all forms of eating pathology. And, this is something we've seen clinically here at UNC. And, there's a good amount of research now being looked at food insecurity, as a risk factor for eating disorders.

Christine Peat (she/her): I highlight some of these here to really get you to start thinking outside the box of what you might typically consider when you're thinking about an eating disorder diagnosis.

Christine Peat (she/her): So, instead of having one particular stereotype in mind, we're really thinking about the reality of eating disorder diagnoses. These are going to be individuals, who look like your family members, your friends, your neighbors, your colleagues. So, keeping that in mind, as you're in your routine clinical practice can really help expand the number of individuals that we detect with eating disorders.

Christine Peat (she/her): In terms of the overall burden, I'll spend just a little time talking about the medical complications, as well as the psychiatric and social complications.

Christine Peat (she/her): We know that, depending on the diagnosis eating disorder really can affect all organs and systems malnutrition in particular has deleterious effects on all body systems.

Christine Peat (she/her): We also see a lot of folks coming in with GI complaints, whether that's some form of indigestion constipation. Maybe bloating just some kind of stomach irritability is very common with eating disorder diagnoses.

Christine Peat (she/her): There can be some very dangerous effects on your cardiovascular system associated with dietary restriction, over exercise laxative abuse, self-induced vomiting. The list goes on and on. And then, of course, there are some very real psychological and social complications with respect to eating disorders.

Christine Peat (she/her): So, we know that folks that struggle with these conditions often have just this running tape player of information and negative eating disorder thoughts running through their minds. And, this can lead to some real difficulties when it comes to attention being present in your workplace or at school.

Christine Peat (she/her): And, this can also lead to things like impaired social functioning where folks with these conditions become so wrapped up in their eating disorder, they become isolated from their family and friends.

Christine Peat (she/her): The eating disorder becomes so important that it pushes out all of the other parts of your life.

Christine Peat (she/her): So more thinking about that overall picture of eating disorder burden, we're really not just talking about the relationship with food, relationship with body, or your weight. We're kind of talking about your overall quality of life.

Christine Peat (she/her): We talked a little bit already about some of the medical complications so we'll skip over that for these purposes. But, in terms of some of the psychiatric diagnoses, I think it's important, especially for those of you who might be generalists to be aware that eating disorders are commonly comorbid with other kinds of diagnoses that you might more routinely see in your practice so substance use disorder somewhere between 27% and 36%.

Christine Peat (she/her): Mood disorders and anxiety disorders are pretty ubiquitous when it comes to eating disorder comorbidity. There are very few patients I can think of, that I've ever treated that didn't have a comorbid mood or anxiety disorder.

Christine Peat (she/her): So, it doesn't hurt to kind of be thinking about an eating disorder as a possible comorbid condition, if you have patients in your practice who also have things like substance use disorders mood disorders or anxiety disorders.

Christine Peat (she/her): Despite the fact that we know that there are significant morbidity and mortality associated with eating disorders, there are some really difficult clinical realities. So, we know that eating disorders actually have the second highest mortality rate of any psychiatric illness.

Christine Peat (she/her): And, really this is largely secondary to substance use disorders and particular opioid use disorder. So, many people are surprised to learn that. But, eating disorders are very deadly conditions and many individuals with eating disorders will die as a result of suicide.

Christine Peat (she/her): And even more frustrating is that, even though these conditions are really serious, life threatening. Maybe, at best, half of individuals with these conditions will receive treatment that they need in order to get to recovery.

Christine Peat (she/her): And, even if they can find treatment, even if they are detected with an eating disorder, finding that treatment can be really challenging. So, any of you here that work in mental health and even those of you that don't, are aware of how challenging it can be to find treatment in your area with your insurance company. And doing that, with a specialty kind of treatment like eating disorders gets even more complicated.

Christine Peat (she/her): There are a number of different barriers to detection, reasons why this isn't happening. Some of this we've already talked about with respect to stereotypes around age, gender, weight, race or ethnicity.

Christine Peat (she/her): But there's also an under recognition of diagnoses that aren't anorexia nervosa, which is part of why I started with OSFED when we were talking about diagnoses.

Christine Peat (she/her): I really want you thinking about what you're more likely to see in practice versus what you're less likely to see in practice.

Christine Peat (she/her): And so, because of that, I think it's important that we're thinking about that full spectrum of eating pathology, not just one particular diagnosis.

Christine Peat (she/her): We also know that very similar to things like substance use disorders, those with eating disorders are actually more reluctant to disclose their symptoms.

Christine Peat (she/her): It's not usually the case that folks wake up and think, I have an eating disorder, I need specialty treatment, I will go to UNC and get care.

Christine Peat (she/her): Usually, these are conditions that really thrive in that isolation.

Christine Peat (she/her): And so folks are doing everything that they can to conceal their eating disorder not talk about it, not acknowledge it. And so, in that way it can be really hard to detect these folks. Again, much like those with substance use disorders.

Christine Peat (she/her): The good news, however, is that early detection can play a crucial role in detecting folks that have eating disorders, getting them to the care that they need and helping them have a better overall prognosis.

Christine Peat (she/her): So, as I mentioned it's rare that patients present directly for specialty care, however, there are many instances in which these individuals might be better detected in a primary care setting or even in a generalist mental health clinic.

Christine Peat (she/her): So in these situations, these patients often have ongoing relationships with their PCP. I can't tell you how many times I've worked with patients who have said, "You know I've been working with my primary care Doc for 5-10 even 15 years and that kind of relationship is so meaningful, and so long standing, that it's kind of the perfect opportunity to introduce these kinds of screening measures.

Christine Peat (she/her): Those that are in a primary care role, or in a more general this role, are also in a really great position to help facilitate referrals to more specialty type clinics. So there are lots of reasons that the primary care or the generalist setting might be the perfect role to be doing this kind of screening.

Christine Peat (she/her): And again, as with almost every mental health condition, every physical health condition, the earlier, we can capture these things, usually, the better the prognosis. Certainly that's not the case, widespread but, overall, usually it means better things in terms of outcomes.

Christine Peat (she/her): So, if you're asking me or anybody else in the eating disorders field who should get screened for an eating disorder we're pretty biased, and we're going to say, everyone should be screened.

Christine Peat (she/her): We know that, given the research that's out there and the statistics that have been compiled that anyone can struggle with an eating disorder.

Christine Peat (she/her): But knowing, of course, that we live in a, in the real world, where there are practicalities in terms of bandwidth for screening, time for screening.

Christine Peat (she/her): I thought I'd highlight a few areas where there is some higher risk for the onset of eating disorders.

Christine Peat (she/her): So one group I'm sure won't surprise you is adolescence, you know those that are kind of in those formative years, right around puberty. And, then thinking about that high school to college transition, these are folks that you have a demonstrated risk of eating disorder onset.

Christine Peat (she/her): Also in that same vein, patients and any kind of key transition periods, so you think about you know transition from college into your first job.

Christine Peat (she/her): You think about weddings, you think about the first child who might be having all of those kinds of major transition points are important to keep in mind as high stress times that might trigger an eating disorder in folks who are biologically vulnerable to developing them. Folks with certain medical conditions are also at higher risk for eating disorders, so those with diabetes, PCOS, any kinds of GI complaints.

Christine Peat (she/her): These are folks that it's super helpful to be thinking routinely about. Whether or not an eating disorder might be comorbid with what's presenting in the in the clinic visit.

Christine Peat (she/her): Also athletes for probably fairly obvious reasons, are at high risk, anyone with a family history of eating disorders, given that we know the genetic loading or the biological predisposition to developing an eating disorder.

Christine Peat (she/her): Anyone seeking help for weight loss is an important for us to be screening for eating pathology, given that we know that major risk factors for eating disorder onset are things like history of dieting and history of living in a larger at a higher body weight, or in a larger body.

Christine Peat (she/her): And, then veterans are also a group that have shown some increased risk with the development of eating disorders.

Christine Peat (she/her): There are lots of reasons that we could go into there, but suffice it to say that there are lots of things that might set you up for an eating disorder when you make that transition from being in active duty into the veteran status and going back to civilian life.

Christine Peat (she/her): I apologize as I need to go back one screen okay. Sorry about that. There was a little bit of funniness on my screen.

Christine Peat (she/her): So as we've talked a little bit about setting the stage for eating disorder screening, the importance of doing this screening sort of the severity of eating disorders.

Christine Peat (she/her): One of the things that we, as an organization really found, was that, even though providers really wanted to screen for eating disorders, primary care docs are telling us sure, I'm happy to do this, I'm happy to help play that role in terms of mental health screening which there. Of course, being increasingly tasked with but I need something that's pretty specific to my practice. I need something that's going to work in a primary care setting where we might have 15 minutes with a patient and during those 15 minutes, we have to take care of a list of all of their other diagnoses. And now we're going to introduce something else right, so they needed, something that was pretty specific for their practice.

Christine Peat (she/her): So what we thought about doing was really leveraging an existing framework that many of you may be familiar with and making the content relevant for eating disorders. So, for those of you that are in a generalist setting or a primary care setting or anyone who does substance use, substance use disorder work, and you're probably familiar with the screening brief intervention and referral to treatment model.

Christine Peat (she/her): Where this is sort of a public health model that's based on harm reduction. The idea that, if we can get PCPs and other generalists engaged in this kind of early detection piece, that it will set folks up for better outcomes when it comes to their substance use disorder treatment.

Christine Peat (she/her): So what we did is, we took that existing framework that has been developed in coordination with primary care docs and has been widespread through our primary care practice, also in medical education and we've swapped the content out to be relevant for eating disorders. I'll talk a little bit about what that means, and what that looks like.

Christine Peat (she/her): But essentially we did this through really in-depth input from primary care providers.

Christine Peat (she/her): As a clinical psychologist myself, I am not a PCP, so I will not pretend to understand what it's like to see that many patients in a day to have such short visits.

Christine Peat (she/her): And so, we really wanted to make sure that what we were developing was going to be relevant for them in their practice so we did a series of qualitative interviews that will talk a little bit about.

Christine Peat (she/her): But this whole protocol is really designed to give providers an evidence-based screener, ways and words that work with their patients who are in front of them struggling with an eating disorder, and then getting them to that specialty care.

Christine Peat (she/her): For people like me who treat eating disorder specifically, we did this in a way that gives PCP really concise information. It's easy to access and it's plug and play. Because we heard from them over and over and over again, it needs to be quick, it needs to be easy to use, and it has to be kind of this just in time type information.

Christine Peat (she/her): Right, so to undertake some of this work, we worked with a group that's here at UNC called CHAI Core and they are really well connected here at the university and their whole, their whole ball of wax is really developing these kinds of digital interventions and making sure that they are relevant to the stakeholders who are using them.

Christine Peat (she/her): So, we work with them to do some of this initial development work where we did a series of qualitative interviews. We recruited primary care providers, those who had familiarity with eating disorders, those who didn't have any familiarity with eating disorders, some that were working in purely primary care offices, some that might be working in college settings. We tried to get as wide a range of these types of stakeholders to really get a full breadth of understanding in terms of the needs for some of these folks when it comes to managing eating disorders in their practice.

Christine Peat (she/her): What you're seeing here, I know is small print so forgive me. But what you're seeing here are some screenshots of some of the interview guides that were used when working with the PCPs for these qualitative interviews, so they were asked a little bit about their experience with eating disorders.

Christine Peat (she/her): What do they know about these conditions? How many patients have they treated with eating disorders, or how many did they suspect that they've treated with eating disorders?

Christine Peat (she/her): We gave them some general information about the SBIRT framework, and then we asked for some explicit feedback from them about the pros/cons of this kind of approach. Is this something that will be useful for them in their practice? Is it not? What are the features that would work well, what are the features that wouldn't?

Christine Peat (she/her): And audio recorded all of these interviews and then pulled out all of the information as we were moving through.

Christine Peat (she/her): And, I'll talk a little bit about these next steps, and for those of you that are in the digital health space are probably very familiar with this work. But, we did a series of iterative user experience sessions, where we sat down as a group here, our NCEED group, in addition to the CHAI group and really thought about okay based on what we've learned from these qualitative interviews on

their primary care doc's, let's develop some of these different personas. What types of PCP do we think at some point might be using this tool?

Christine Peat (she/her): What kind of practice do they work in? Are they in a rural setting? Are they in a more metro setting that they see mostly adults, or do they see more children? Are these folks that are new to practice, or they've been practicing for 30-40 years?

Christine Peat (she/her): Again, when we're thinking about doing this launch we're really thinking about doing this on a national scale. So, it was important for us to be thinking about the full range of stakeholders who might be using this tool at some point.

Christine Peat (she/her): And so we came up with a number of these different personas. We paired them up with different types of patients that they might be seeing.

Christine Peat (she/her): Everywhere, from a patient who says I know I've had an eating disorder, I've been diagnosed, but I really don't necessarily want to address it. All the way through folks who would have never conceived that they were actually struggling with an eating disorder.

Christine Peat (she/her): They thought it was just, that it was just a condition that they had struggled with their whole life, but just sort of figured it was idiosyncratic to their experience.

Christine Peat (she/her): And so, in this process it really got us thinking about okay, given the complexities of the different types of PCPs that are out there, given the complexities of the different types of patients, and the different diagnoses that might be coming up.

Christine Peat (she/her): And, then you think about the matrix where all of those things kind of intersect. We really started to think about how this tool might need to function to meet the needs of all of those different kinds of stakeholders.

Christine Peat (she/her): And I hope what you're really getting a good sense of here is just the complexity when it comes to developing the tool that's going to address the needs of all these different kinds of stakeholder groups, and so, with that in mind, I can get this to work.

Christine Peat (she/her): We developed some wire frames, where we started thinking about okay, if we take this down to brass. What are the features that are going to be most important? We know that there needs to be a screener, we know that we need to give providers some specific words to use and working with their patients.

Christine Peat (she/her): We know that we're going to need to give them some sort of outcome that they're going to be able to learn something from the results of this screener and then be able to do something about it.

Christine Peat (she/her): Because that's what we heard over and over again from the primary care doc's was that I'm happy to help I'm happy to screen.

Christine Peat (she/her): But, if I'm going to screen for something I need to know what to do about it. If somebody screens positive I can't just be left holding the bag, knowing that someone has an eating disorder and not then being able to document that I've done something about it.

Christine Peat (she/her): So, we started to come up with some of these initial wire frames. Thinking about you know everything down to what kinds of what, what, we will we want these buttons to look like when we want these to be radio buttons. Will we want these to be text boxes? All these different things.

Christine Peat (she/her): Things that I think when you look at something on your phone you're already just kind of used to looking at it you're used to seeing things presented in a certain way, but when you're building it from scratch there's a lot of these decision points to make.

Christine Peat (she/her): And so, what I'm going to show now is just a series of screenshots for the tool that we have done a mock up for. This is not our final offering, this is just the mock up that we've developed with CHAI Core.

Christine Peat (she/her): And I'll talk a little bit about where we are in terms of development after we've had a chance to walk through this.

Christine Peat (she/her): But, this overall is the mock up for the website that we have now developed in in collaboration with CHAI Core that we have mocked up with, I'm sorry.

Christine Peat (she/her): And you might be wondering at first, did you just say website? So, this is going to be a website, not an app and the answer to that question is yes. We heard overwhelmingly from our primary care doc's that there is no way that they were going to download an app onto their phone and pull out their phone during a clinic visit.

Christine Peat (she/her): Pull up that app, enter the information, and then somehow have to email that to themselves to put it into the EMR. There were just too many points of friction, too many points in which they might stop and not actually use this tool.

Christine Peat (she/her): But when asked if they would use a freely and publicly available website. Is that something that they would have an appetite for? The answer was yes.

Christine Peat (she/her): But, if this was available to them, easy to use, they could download a shortcut on their laptop or on their tablet that, that's, something that would be more amenable to their practice. So, we've built this as a website, this would be the homepage you would see when coming to the website gives you some brief information about SBIRT and what it's for.

Christine Peat (she/her): You would then click the get started button and you're presented with the first two screening questions.

Christine Peat (she/her): Those of you that are familiar with eating disorders screening, you're probably familiar with the SCOFF. And, the SCOFF is what we have used for the purposes of this particular SBIRT for eating disorders protocol.

Christine Peat (she/her): What you're seeing here are the first two questions, not necessarily in terms of order. But, there were a couple of research studies done looking at which of the items from the SCOFF are the most sensitive. Which were the ones that were really going to be the best at overall detecting eating disorders.

Christine Peat (she/her): And you might be wondering why we're doing this, especially for those of you that are eating disorder clinicians, eating disorder researchers, thinking, "Oh my gosh we're losing a ton of nuance here."

Christine Peat (she/her): And you're not wrong, but the reality is in primary care, you have maybe 15 minutes, and in those 15 minutes you have a ton to accomplish.

Christine Peat (she/her): So we don't have the luxury of time for administering even a 28-item measure like the Eating Disorder Examination Questionnaire, for example.

Christine Peat (she/her): And, in fact when you look at other screenings that are done in primary care things like anxiety and depression.

Christine Peat (she/her): They have whittled down those screeners to just a couple of questions so many of you are probably familiar with the PHQ, the PHQ-9, the PHQ-7, the PHQ-2, and the PHQ-2 was what are routinely used to detect depression in a primary care setting.

Christine Peat (she/her): So we thought about again, how can we get as many PCPs to use this as possible? We thought about making the parallel to other things that they're already screening.

Christine Peat (she/her): So, we picked the two items that were found to be the most sensitive. If a patient were to answer no to both of these questions, they would be considered a screen negative.

Christine Peat (she/her): If, however, a patient says, yes, to either of these questions, and they were administered the final three questions from the SCOFF, and these radio buttons are just filled in to give you a sense of what that would look like when they're completed.

Christine Peat (she/her): So, once all five questions have been administered. For those who said yes to either the first two, the providers are given a results page. So, in a matter of two clicks we've gotten to a place where the PCP is given the results of the screener, what they're going to do next and then, the patient facing information as well. And I'm going to walk you through each of these in turn, because I know it's a lot to look at.

Christine Peat (she/her): But, if you look at the top of the screen, there were the yellow box is, where it says medium risk or risk level medium.

Christine Peat (she/her): This is just a mock-up of a patient who might be determined to have a medium risk for an eating disorder.

Christine Peat (she/her): I know it's somewhat arbitrary but, again, we were thinking about all the parallels that exist when it comes to other screening conditions that PCP are engaged in.

Christine Peat (she/her): So, if you think a little bit about alcohol use disorder, for example, that's actually what SBIRT was originally designed for was for the management of alcohol use disorder in primary care.

Christine Peat (she/her): And, when you do an alcohol screening, a PCP has told your patient as a medium risk for an alcohol use disorder, because he or she is drinking X number of drinks per week, or they're at high risk for an alcohol use disorder because they're drinking even more drinks than that per week, for example.

Christine Peat (she/her): And so, we wanted to have a parallel when it came to eating disorders, so what we've given here is just for an example, a medium risk level for an eating disorder.

Christine Peat (she/her): And then that whole box is something that they can click and then immediately put into the EHR.

Christine Peat (she/her): And what's here is very parsed down, it is very brief but it's what our PCP has told us in terms of how they document each of the problem areas.

Christine Peat (she/her): So they need to know what the results of the screen were, they need to know, they need to be able to document what it is that they did as a result of those screening results. And then, what they're going to do next at the next visit to make sure that this is a continuing plan of care.

Christine Peat (she/her): So we've mocked up this kind of language and again we are open to iterations. We're open to refinement especially based on feedback from folks starting to use this.

Christine Peat (she/her): But this is kind of what we've initially envisioned for this section for primary care providers to put into the EHR.

Christine Peat (she/her): So that's kind of that first page in terms of results at the bottom of the screen. What you're going to see is kind of that brief intervention component of the SBIRT protocol where we've given providers ways and words that work, what are some of the things that you want to say to a patient if you know that they screened positive for an eating disorder.

Christine Peat (she/her): And again this goes, all the way back to our initial qualitative interviews that we did. Our PCPs had told us listen, I am fine with doing the screening, knowing that there's an evidence-based measure out there that's great. But, what do I say to this patient so that I don't make their eating disorder worse? What kinds of words, I want to use, how do I talk about food and weight in a way that's compassionate and informed and is in a way that isn't going to necessarily make them feel even worse, about the fact that they've screened positive or worse in terms of their eating disorder?

Christine Peat (she/her): So we've come up with a series of different scripted prompts in some of these different areas.

Christine Peat (she/her): The expectation is not that the PCP will cover every single one of these areas in the in the course of the visit, but they might pick the areas that are most salient to them.

Christine Peat (she/her): So maybe they want to have a conversation about the specific responses from the screener maybe they want to talk a little bit about the risks of some of engaging in some of these eating disorder behaviors.

Christine Peat (she/her): Or maybe they just want to talk a little bit about reducing overall stigma to help increase motivation to seek specialty care. So on the next screen you'll see sort of the expansion of one of those accordions where you can see the content of some of those scripted prompts for the primary care providers.

Christine Peat (she/her): Again, these are just examples of texts, these are not best and final, and this is what we have in here for now.

Christine Peat (she/her): Just helping folks think about how would I approach someone who I'm concerned about an eating disorder and so we've given them just some general starters, for those topics of conversation.

Christine Peat (she/her): And I'm just going to check my slides real quick, yes, I want to go back to one.

Christine Peat (she/her): So then, what I don't have are the available text for each of the other accordion areas, but it's a very similar kind of process where the PCP can choose any of these different areas, and then engage in conversation with their patient based on the areas that might make the most sense in that visit.

Christine Peat (she/her): And then, in terms of next steps in terms of that referral to treatment component, it's the step by step referral guide that we have developed.

Christine Peat (she/her): It is designed to be patient facing, but it has a lot of utility for providers as well, so what we're thinking about in terms of this step-by-step referral guide is this is something that can be given to the patient and a number of different ways and really walk the patient through how to find care in their area based on their zip code or their city and location, based on their insurance status. All of those sorts of things. And then, it actually gives the patient, a script of what to say when you're calling those places or an email template if you're emailing them.

Christine Peat (she/her): Just to try, try and take a lot of the guesswork out of it. If any of you have ever been in a position where you are referring people for specialty care it's one of those things that I think you recognize there's a lot of onus, on the patient to do.

Christine Peat (she/her): The setup of these appointments, or to call these places, and it can be intimidating to do that if you don't know what to say.

Christine Peat (she/her): So we've tried to take a lot of that guesswork out of there and put all of this in a comprehensive, step by step referral guide that patients can have access to. And we'll talk a little bit about that here in a moment.

Christine Peat (she/her): In addition to all of that, we also have some static resources that are available in terms of self-help, right. So we've given patient access to widely available self-help resources. Again, these are just quick examples, this is not an exhaustive list.

Christine Peat (she/her): But just information for folks to be aware of, so that they know that there are some things that they can be working on while they're waiting for a call back, or while they're waiting for their first appointment. Those sorts of things.

Christine Peat (she/her): So when you think a little bit about the overall workflow, what you can see is that we have developed these different components to fit into the screening brief intervention and referral to treatment model. So, the screening of course is the SCOFF and that's where somebody can either be a screen positive or screen negative.

Christine Peat (she/her): If they're a screen negative, then there aren't any further steps. If they are a screen positive, then you move on to that brief intervention component.

Christine Peat (she/her): And that brief intervention component mostly consists of those scripted prompts. The patient facing referral guide and then I'm sorry, descriptive prompts and the patient resources.

Christine Peat (she/her): And then the referral to treatment component is that referral guide and it's the information that we have in terms of giving that directly to the patient, but then also making sure you follow up on that referral process at the next visit.

Christine Peat (she/her): Because, again, sometimes people's motivation can lag sometimes it gets lost in the shuffle or folks aren't motivated to make any changes at that point.

Christine Peat (she/her): And that, again, is where that PCP role can be so crucial. Because if you're having regular follow up visits with these folks whether it's once every 3, 6, or 12 months, it gives you the opportunity to raise the conversation again in a way that leverages your existing relationship.

Christine Peat (she/her): In terms of the overall flexibility, as I mentioned before, not only were we thinking about the different kinds of providers that might be out there, the different kinds of patients that might be out there, we also recognize that the overall settings are really going to vary depending on how well, how well resourced, you might be. So you know, for example, when we're thinking about giving a patient that, step-by-step referral guide, there are some clinics out there that are super well-resourced and are going to be able to give patients fancy tablets in the waiting room to fill some of these measures out. Maybe they have a digital EHR that can send them these different things.

Christine Peat (she/her): But they're also going to be places that are still relying on paper and pencil measures and so when we are thinking about a nationwide launch, we wanted to make sure that we were really adequately capturing the full range of different types of clinics settings that are out there, so really this whole framework was designed to be as adaptable as possible.

Christine Peat (she/her): Making sure that anybody who wants to use it can use it in a way that makes sense in their practice.

Christine Peat (she/her): Are there tweaks still to be made sure, but this is, I think sort of the, the best offering that we have at this time, to make sure that folks can use this in a way that's relevant for their practice and the end their population that they're seeing.

Christine Peat (she/her): In terms of overall next steps we posted the request for proposals to work with a digital health company to actually go ahead and do the build of this SBIRT website in November.

Christine Peat (she/her): And you can see some of the next steps here. Excuse me, my screen is not working, so we did that in November. We selected a vendor this was probably a week ago, or less than a week ago, and we anticipate doing a launch in, I'm sorry doing the development in late 2021 with a launch anticipated in early 2022. So, what you're seeing here today is really a sneak peek of what's to come.

Christine Peat (she/her): We are very excited about the vendor that we will be working with. We think there's going to be some great opportunities to take. What we've initially mocked-up and make it even more impressive. And then it'll be ready for us, in collaboration with SAMHSA for a nationwide rollout in the early part of 2022.

Christine Peat (she/her): So this is a little bit about what's to come down the pipeline, specifically when it comes to our SBIRT for eating disorders rollout.

Christine Peat (she/her): But in the meantime, I would encourage you to check out some of the resources that we have available on our site.

Christine Peat (she/her): And also, more importantly, to get signed up for our newsletter if you're not already signed up for it, that's going to be the best way to make sure that you have the most up-to-date information about when we're rolling out SBIRT for eating disorders. We're going to do a big press push and all those things too. But, in terms of just getting access to the tool on the ground, signing up for our newsletter is the best way to do that.

Christine Peat (she/her): So in addition to that, on our website, you can find this toolkit that we've created for primary care partners. For anyone who is interested in working or collaborating with us, there's all kinds of information in terms of infographics, there's videos, there's our newsletter archive. So, please make sure to avail yourself of those resources.

Christine Peat (she/her): In addition, for those of you that are in primary care, we've also come up with just a brief checklist in anticipation of the rollout for SBIRT.

Christine Peat (she/her): So what are some of the signs and symptoms of eating disorders to be aware of? These are just some quick screenshots for you to take a look at.

Christine Peat (she/her): What are some of the early recognition signs or steps that you can be taking.

Christine Peat (she/her): What are some of the questionnaires that are validated out there for screening in case the SCOFF isn't one that necessarily works for your practice? Again, you can find all of this on our website.

Christine Peat (she/her): You can also go to our full list of resources and our resource library, where on the left hand side, you can see that we have a number of different filtering capabilities. So, all of the resources that we have, they can be filtered down, depending on whether or not you're a therapist maybe you're a primary care doc and you want to learn specifically about medical management.

Christine Peat (she/her): It will tailor those resources based on some of those filtering capabilities and then also our Training Center that I know was mentioned at the beginning of our webinar.

Christine Peat (she/her): All of the trainings that we have done so far in this webinar series or logged there, we have a wealth of offerings for primary care doc's.

Christine Peat (she/her): We have a number of different offerings for folks that might be behavioral health facing and are interested in learning about let's say conceptualizing recovery or working with certain you know minority populations of eating disorders. All of those are available, free, on our website. They're also associated with free CEU, free CME, so please take advantage of any of those that might be interesting to you or to folks that are in your clinic, or your practice.

Christine Peat (she/her): And just in terms of some overall summary, I wanted to leave you with some of these points. And I'm glad that we'll have some time for question and answer, and I know that La-Shell will be helping us to facilitate that.

Christine Peat (she/her): But I just wanted to kind of leave you with the overall setting the stage information of the number of folks that will struggle with an eating disorder.

Christine Peat (she/her): And, knowing that folks that are in primary care or in a generalist role have a really crucial role when it comes to screening these conditions, detecting them, and getting them into treatment as early as possible.

Christine Peat (she/her): And, we're hoping that what we've developed with SBIRT for eating disorders, will be a tool that is practical and useful for those of you who are engaged in this work.

Christine Peat (she/her): So with that, I'm going to turn things over to La-Shell who's going to help us facilitate a question and answer session. The only other slide that I have is my email address. In case anyone wants to be directly in touch after the talk, I'm happy to walk through any of this information with anybody. So, La-Shell I will turn things over to you.

la-shell_johnson@med.unc.edu: Thank you so much Dr. Peat for such a great presentation.

la-shell_johnson@med.unc.edu: As a reminder, we will be sending the slides after the presentation has ended. We will now begin our question and answer segment. We have quite a few questions. For any unanswered questions, we will send those responses to you via email within one week from today. So, just as a reminder, you will receive those responses one week from today via email. I'll go ahead and start with our first question and it says, it seems that the two questions do not screen for restrictive behaviors, I'm not sure which two questions. I'm not sure if you could decipher, Christine.

Christine Peat (she/her): Sure yeah, so I think the person who's asking the question is probably referring to those first two questions on the SCOFF that are presented there. And, you're right. They don't adequately screen for those sorts of things, and I think the balance here that we're really trying to achieve like what all screenings is the balance between specificity and sensitivity. So, in this situation,

we want to make sure that we are going to pick up as many people with an eating disorder as possible, so we want the measure to be as sensitive as possible, even if we have to sacrifice some of that specificity.

Christine Peat (she/her): And again, based on the research that was done, not by our group, but by lots of other folks looking at which of the five questions on the SCOFF, we're the best at detecting the widest swath of individuals with an eating disorder. Those are the two questions that came up.

Christine Peat (she/her): But absolutely you're right, it is not necessarily something that's going to adequately capture everyone, but we're simply trying to move the needle from no screening at all at a primary care setting, to at least some screening and detecting as many people as we can. Certainly, there's room for refinement, and if you have other thoughts or suggestions, I would absolutely encourage you to reach out. We're happy to take any thoughts that you might have.

la-shell_johnson@med.unc.edu: Thank you so much for that response Christine. The next question reads, "Can this to be placed inside a flow sheet?" For example, in EHR such as EPIC.

Christine Peat (she/her): Yeah, but I love that question. And it is absolutely something that we are working towards. So, I'll just be transparent, that in terms of practicality, we had to start with a website. If we wanted to start with an EHR, we wouldn't be rolling this out for the next five years, probably.

Christine Peat (she/her): It's just for those of you that do this kind of work, you're aware of how challenging it can be to get things into the EHR. But, from our perspective, when we built this and we started to develop this as a concept, and as a protocol, the whole goal really is to cannibalize it. To put it into an EHR because, ultimately, that was the number one thing that we heard from the primary care doc's was, yes a website is fine. We're not going to use an app as a standalone app, so website will be better. But even best is going to be to have it already embedded in the EHR. I think there are a number of positive signals that we've had from some folks who are in the know in some of these larger EHR systems like EPIC or Cerner. We've had some really positive discussions early on, about this becoming a reality, but for now, in terms of the rollout we're going to start with this.

Christine Peat (she/her): And then eventually, yes, we hope to have a face into a workflow very similar to what you might do for best practices around depression, anxiety, any of those other kinds of conditions. Great question.

la-shell_johnson@med.unc.edu: Thank you again, Christine. The next question reads, "Is the screener and referral PDF available in Spanish?"

Christine Peat (she/her): Wonderful question! It is not as of yet. However, when we do our launch, we will make sure to have that available in Spanish. Thankfully, on the team on the NCEED team, we have someone who is an expert in Spanish language translation specifically around eating disorders. So, what we will make sure that that is available in Spanish. Great question.

la-shell_johnson@med.unc.edu: The next question reads, “Any cultural adaptations needed for Latinos, African American, Vietnamese, LGBTQ populations?”

Christine Peat (she/her): Yes, thank you so much for that question. And one of the slides that I didn't have in this presentation, are sort of our planned iterations for SBIRT for eating disorders. So, knowing that this is where we're starting from, we also knew that not only do we want this to go into the EHR, we knew that we were going to have to make adaptations, depending on the different types of patients that might be in the clinic.

Christine Peat (she/her): So, to that end SAMHSA actually has developed, or stood up a couple of different Centers of Excellence that we are thrilled to be working with in the coming months, actually. So for those of you who may not be familiar, SAMHSA actually funded several Centers of Excellence, specifically focusing on behavioral health disparities. So, in the last I think it was six months, they funded a Center of Excellence on Behavioral Health Disparities in the African American Community, in the LGBTQ Community, for families, I think the homeless community, and then one other. But, we plan on working with all of the different SAMHSA CoEs to make some of those adaptations to make sure that the content that we have is appropriate for the patients that it's serving. Certainly that's not an exhaustive list of the iterations that will be undertaking, but it gives you a sense of where we're headed.

la-shell_johnson@med.unc.edu: Thank you once again for that reply Dr. Peat. The next question reads, “Is recovery record a standalone ED treatment app?” I thought this app tracks ED symptoms and is intended to be used in tandem with a treatment team?”

Christine Peat (she/her): Yeah, that's a great question. So one of the things that I don't think is, is clear from that particular screenshot, is that there is a self-help version of Recovery Record that is designed to be sort of used as a monotherapy.

Christine Peat (she/her): So that is that's one possibility, but if there are other suggestions about other treatments or other things that are sort of self-help type interventions, I would love to have a list of those. We'd be open to any of those kinds of collaborations. Again, nothing that was shown on that screen was meant to be an exhaustive list, these were just mock ups, with some initial ideas. So certainly feel free to make sure that you're giving us feedback on that as well.

la-shell_johnson@med.unc.edu: Thank you again, Dr. Peat. The next question reads, “In what populations has this tool been checked for reliability?”

Christine Peat (she/her): So if you're referring to the SCOFF that's a great question. So, the SCOFF itself has largely been validated in adult populations.

Christine Peat (she/her): And that's one of the real challenges that we have when it comes to children and adolescents. We can talk about that separately but, the SCOFF has been validated for adults in terms of being a valid and reliable screener. Again screener, not diagnostic tool, but a screener for eating disorders in a primary care setting. So, it's actually being used and let's say campus health settings, or another more generalist type setting, so we know that there's reliable and valid information when it comes to using this SCOFF in this way.

Christine Peat (she/her): When it comes to evaluating SBIRT for eating disorders. This is a novel protocol, this is the first of its kind, and of this is something that we have developed here within NCEED.

Christine Peat (she/her): And so we are looking forward to doing some formal program evaluations and formal data collection, with some, some different primary care partners that we have some discussions going on with and we'll be able to share those data as we do the rollout.

la-shell_johnson@med.unc.edu: Thank you once again, Dr. Peat. I will read the next question, "Do you have resources regarding finding treatment for individuals with eating disorders?"

Christine Peat (she/her): Yes, we certainly do, and that will be included in the referral guide that we give to patients. But in the meantime, if you, yourself, are a provider and you're looking for those sorts of referral sites or information. You are welcome to be in touch with us here through our auspices, you can shoot me an email but there's also some information about that on our website so you're welcome to take a look at the offerings that are there.

la-shell_johnson@med.unc.edu: Thank you once again, Dr. Peat. The next question reads, "IADEP has a task force working on this identical issue, how are you addressing linking PCPs to ED specialists, therapists, dieticians, family support, etc.?"

Christine Peat (she/her): Yeah so, it's interesting. I'm aware of some of the efforts that IADEP has going on in this arena, and I think that really what we are trying to focus on with SBIRT for eating disorders is the earliest part of that pipeline. So, really just getting and we talked about this in our UX sessions what we're really trying to do is to just get PCP's to consider that an eating disorder diagnosis might be part of the clinical picture. Just even getting them to think, maybe, I should include an eating disorder an eating disorder screening in sort of the, the routine screeners that I give to people. That in and of itself represents a huge clinical shift. So, just even introducing that as a concept is going to be enormous win, when it comes to detecting people with eating disorders.

Christine Peat (she/her): The next part of that pipeline is exactly what IADEP was talking about. It's that integration of connecting people who are in that primary care setting with eating disorder treatment providers for patients who are receiving ongoing care or ongoing management.

Christine Peat (she/her): I am happy to have some of those conversations for those of you who may be on that task force. Please reach out to me I'd love to talk to you about that.

Christine Peat (she/her): But in terms of what our protocol is designed to do, it's really designed to kind of be at the earliest part of that pipeline.

Christine Peat (she/her): To just sort of socialize this idea that eating disorder screening is something that's important to be happening in a primary care setting and saying, hey look we've already developed this protocol in conjunction with PCPs that should work in your particular setting. And then, as other parts of the pipeline kind of get involved, and we're all kind of working in tandem, we've got everybody kind of moving in the same direction.

la-shell_johnson@med.unc.edu: Thank you once again, Dr. Peat. The next question reads, "Referral to treatment can be so challenging with patients without insurance, any suggestion on working with low income patients without health insurance when it comes to referring to treatment?"

Christine Peat (she/her): Yeah gosh, you know I. Boy, we could talk all day about this, and just how challenging it is you know. As a clinician here in North Carolina, you know, the number of folks that we end up seeing who are covered by Medicare and Medicaid, or uninsured, or frankly just under insured, it is such a challenging problem.

Christine Peat (she/her): And, in the absence of having a magic wand, where I can say, you know, here's a list of 50 places that you can send someone. What I would say, is to check with any of the existing networks that you have in terms of eating disorder providers. Because many of them will offer either sliding scale appointments, or some of them do pro bono work. Also Project Heal has treatment scholarships that can enable folks to access that treatment for folks that might not otherwise have means. Depending on the level of care that folks are looking for, a lot of the places that offer inpatient care that are university based often, will take Medicare or Medicaid. So, I think it's important to kind of be thinking about the specific resources in your area.

Christine Peat (she/her): The other thing I would say is that there are some really great free online support groups. Even though it may not take the place of a full suite of treatment, we know that it may not meet all of those needs. Organizations like the Alliance for Eating Disorders offer free support

groups for folks, and they're doing them all virtually in light of the pandemic. So again, is this a perfect fit? No, but there are at least some resources that are out there.

Christine Peat (she/her): So, if there are specific, however, I would encourage you to be in touch with us and we can see what we can do to kind of answer any specific questions that you might have for patients that are in your area.

la-shell_johnson@med.unc.edu: Thank you once again, Dr. Peat. The next question reads, "Has this been implemented in college health centers?"

Christine Peat (she/her): So if you are referring, if the person asking the question is referring to the SCOFF, the answer is yes. But, if you are referring to SBIRT for eating disorders, as a whole, the answer is pretty straightforward. It's a no since it's not yet developed. We're hoping to launch in the spring. And again, I really want to stress this idea that we are leveraging an existing framework for Screening Brief Intervention and Referral to Treatment.

Christine Peat (she/her): But it being applied to eating disorders, is a completely novel strategy it's something that's being developed here at NCEED.

la-shell_johnson@med.unc.edu: Thank you once again, Dr. Peat. The next question reads, "I am involved with running a summer program for teens, during which we as administrators often see ED behaviors in our participants. We are not PCP's, but want to ensure that the 15 to 20 year olds, with whom we work get care and resources, what would you say to someone in our positions first? And second, what is the most practical way to support these young people, especially since we are not PCPs?"

Christine Peat (she/her): I love that question Thank you so much for asking that. So, I think an answer to the first part of your question, I would say shoot me an email. Because I'd love to have a discussion with you about how NCEED can help support some of the work that you're doing.

Christine Peat (she/her): The other thing I would say is that, in terms of the sort of future plan 5-10 years down the road for NCEED and SBIRT for eating disorders as we're also thinking about, not just frontline clinicians, but frontline individuals. And how we can adapt the content of SBIRT for eating disorders, to be relevant, not only for medical professionals, mental health professionals, but anyone who's on the front lines of testing and eating disorder.

Christine Peat (she/her): And we're thinking about this, we certainly think there's going to be relevant for school settings we think it will be relevant for community settings anybody who's in.

Christine Peat (she/her): You know, like you said in the summer programs that you might be leading people who are leaders of their faith based communities.

Christine Peat (she/her): These are people who honestly are probably going to hear about eating pathology or an eating disorder, maybe even before a primary care doc or a pediatrician. So we do have future plans to make some of those adaptations as well, to make sure that this protocol is something that can be useful for any kind of frontline person.

Christine Peat (she/her): But in the interim, for the person who asked this question, there are resources on our website in terms of messaging around eating disorders, what do you say to young people with eating disorders, how to avoid triggering language. All those sorts of things, so I would encourage you to take a look at the resources that are there.

Christine Peat (she/her): And, if after reviewing those it doesn't feel like it quite fits the needs of what you all, are doing, please reach out to us for that kind of technical assistance. That's really what we're here for, is to provide that kind of ongoing education and training to anyone who's engaged in this kind of work, so thank you for that.

la-shell_johnson@med.unc.edu: Thank you once again, Dr. Peat. I will try to get two more questions addressed, before we end our session. The next question reads, "What percentage of the 15 minute appointment ends up being dedicated to this screening and intervention?"

Christine Peat (she/her): Yeah, good question. You know, I think it really kind of depends on the resources that are available in the clinic. So, we envision that for people who are clinics that have an electronic medical record, they might be able to send the screener to the patient in advance of the visit. So, for many of you I'm sure this is very common in your primary care visits, where your doctor's office is probably sending you three or four questionnaires that you have to fill out before you come in.

Christine Peat (she/her): There's no penalty, of course, if you don't fill them out, but it helps to facilitate the visit right. So, in that situation really, the major component would be having the discussion with those scripted prompts and referring a patient to care during the visit. So, it may only take a matter of a few minutes. If, however, you're needing to do the full thing during the visit. We also envision that for people like CMA's and CNA's, it could be really crucial in this. So, as they're rooming a patient, as they're getting a patient ready to see the doc, they can ask some of those questions, maybe verbally, maybe paper and pencil, whatever makes sense for the clinic visit.

Christine Peat (she/her): So, I think it really kind of depends on how well resourced the clinic is, but again that's why we made SBIRT for eating disorders and to something that's really flexible and really adaptable, depending on the type of setting that you're in.

la-shell_johnson@med.unc.edu: Thank you once again, Dr. Peat. The next question reads, "Will a video of this presentation be available for use with our clinics?"

Christine Peat (she/her): So, this video will certainly be available, this will be on demand content in our training library. However, we are also going to launch a specific training when we do the nationwide launch for SBIRT for eating disorders, so we will have kind of a standalone, for lack of a better term, implementation webinar for folks that are hoping to use this in their clinics.

Christine Peat (she/her): So, the answer is that, yes, this presentation will be there. But, there'll be an additional one that's kind of more specific to the actual build and the full implementation in your clinic.

la-shell_johnson@med.unc.edu: And this is the last question will address today. The others will be sent via email. "What is the plan for piloting this tool?"

Christine Peat (she/her): Yes, so um. There are multiple plans for piloting this tool, I think, you know, we have a number of academic partners who are interested in working with us in terms of overall piloting. There are also some other plans and other discussions with groups that might be interested in doing this in a smaller scale.

Christine Peat (she/her): But overall, if you, whoever's asking this question have, has any interest in being a part of those collaborative efforts, I'm happy to have that discussion. I think the more data we can collect the better. And the better we can get refining this and making sure that it's really adequately meeting the needs of not only the providers who are using it, but also the patients that it's serving. So, absolutely there are plans for that, and when they're more formally in the works we will be able to share some of those data.

la-shell_johnson@med.unc.edu: Thank you once again, Dr. Peat. Do you have any closing statements or any information you'd like to share before we end the webinar today?

Christine Peat (she/her): Nope. I think that's it. I'll just make sure that everything is available so that you can send it out to the larger group.

la-shell_johnson@med.unc.edu: Alright, thank you all for attending today's webinar. As a reminder, we will be sending these slides and the questions to you once the webinar has ended.

la-shell_johnson@med.unc.edu: And you will receive responses to the unanswered questions within one week from today. This session will be available on demand at our Training Center which is www.ncedus.org/training. Thank you all once again for your time and for attending today's session.

Christine Peat (she/her): Thanks everybody.