Hello! Thank you in advance for your willingness to read my testimony as a registered dietitian in the field of eating disorders. My name is Mayah Heffler and I have worked in the field of eating disorders for the past 7.5 years, specifically for Eating Recovery Center. I have completed my master's in clinical nutrition and my certification as an Eating Disorder Specialist (CEDS). I currently work at our hospital in Denver, Colorado where we treat patients at the highest levels of care: in-patient, residential, and partial hospitalization. We see patients from across the country, of all ages, and various socioeconomical backgrounds. Despite their differences each case has one thing in common: our patients are struggling and miserable in their lives. I am grateful to work with an interdisciplinary team that supports, guides, and educates patients and their support systems throughout each level of care.

As the dietitian on the team, I monitor weight trends, adjust calories to meet individual energy needs, collaborate with patients on working through food rules and/or anxieties about specific foods, and educate both about the role of nutrition in recovery and impacts of eating disorders on the body. Dietitians are largely responsible for daily calculations related to weight percentages, body mass index (BMI), and calories provided per kilogram to assess appropriateness of our interventions, specifically the meal plans. This information becomes incredibly important to assess for potential medical dangers, discuss progress with patients, and address concerns for any eating disorder behaviors a patient may be engaging in.

Since our patients at times struggle with transparency related to their illness, having this data and being able to communicate with insurance companies our clinical concerns is imperative. I'd like to briefly share a case that highlights how these objective measures of data are used to advocate for insurance coverage for our patients throughout the treatment process. Please note, the name has been changed to protect patient privacy. Meet Sandy, a 26-year-old female, with a diagnosis of anorexia nervosa-binge eating/purging type. Sandy reported engaging in daily restricting of calories and constant movement due to her active job. The patient's support system expressed patient was also struggling with purging via self-induced vomiting as evidenced by presentation of Russell's sign on both forefingers. Russell's sign is the callusing on the hands due to frequent purging. During my initial assessment patient denied engaging in intentional purging behaviors, suggesting an inconsistency of patient's report (no purging) and objective observations (Russell's sign on both hands). Additionally, Sandy reported a history of sexual assault, PTSD diagnosis, and substance abuse.

Her weight at time of admission was 90.6 lbs. Patient reported a weight history of 130 lbs in 2019, with a weight loss of ~40 lbs over the past two years, approximately 30% of her body weight. Due to Sandy's significantly low weight, 72.5% ideal body weight (IBW), BMI of 15.1 kg/ (m^2), and percent weight loss the team advocated for insurance coverage initially at the in-patient level of care. During the first two weeks at in-patient, patient demonstrated the ability to interrupt eating disorder behaviors and insurance stepped this patient down to the residential level of care despite only gaining ~2 lbs over 2 weeks. Patient was 73.8% IBW and BMI of 15.3 kg/ (m^2). Please understand due to the unique energy needs and metabolism of our patient population it typically requires a significant amount of calories for our patients to gain weight. Due to potentially life threatening complications of re-introducing nutrition it can take several weeks for weight to consistently trend in the positive direction while dietitians are working with patients to increase their oral intake.

Our treatment team advocated these concerns with insurance and emphasized the importance of completing 100% of weight restoration while in treatment. Sandy continued to report minimal urges and consistently interrupted eating disorder behaviors within this level of containment. Due to the lack of behaviors, Sandy appeared on paper ready to step down to an out-patient level of care. However, our treatment team continued to advocate with their insurance company for full weight restoration in treatment to provide Sandy with the best changes at maintaining recovery. She was able to gain a total of ~40 lbs and discharged at 106% IBW with a BMI of 22.1 kg/(m^2) prior to discharge. Without these objective pieces of information, I believe her insurance company likely would have cut her treatment early leading to an increased risk of relapse potentially requiring additional treatment at higher levels of care in the future. I have devoted my professional career to supporting the recovery of patients with eating disorders who come to care in all sizes and shapes. By excluding patients with Anorexia Nervosa in all of its presenting forms, we will inadvertently harm a specific subset of patients in need of treatment and support by decreasing their access to higher levels of care they very much need. I request an amendment to this bill so that ALL forms of Anorexia Nervosa

including Anorexia Nervosa-restricting subtype, Anorexia Nervosa- binge eating/purging subtype and Atypical Anorexia Nervosa all be included. Thank you again for your consideration!

House Public & Behavioral Health & Human Services
04/27/2023 01:30 PM
SB23-014 Disordered Eating Prevention
Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
McKenna Ganz For The Eating Disorder Foundation	Eating disorders remain widely misunderstood and stigmatized, yet resources, education, and support services are scarce. Approximately 10% of Coloradans are impacted by eating disorders, which are also among the deadliest of all mental illnesses. While Denver has become a leading hub for eating disorder treatment, assistance is still not readily available to everyone. In the past three years, our members have reported a lack of food in grocery stores and on their home pantry shelves, loss of household income, cancelled healthcare appointments, worsening of co-occurring issues, feelings of anxiety and isolation, limited access to behavioral health services, and disruptions of normalcy. Just among our virtual support groups, we saw a 1000% increase in new members compared to 2019. The diagnosed incidence of eating disorders was 15.3% higher in 2020 overall compared with previous years - yet, support became even more difficult to access. Unfortunately, eating disorders thrive on isolation, shame and secrecy, and our national circumstances over the past three years have been a breeding ground for each. Not only does the current situation exacerbate and amplify existing eating disorders and trigger relapse or recurrence while in recovery, we have also seen a critical level of new cases throughout our community. Eating disorders are persistent and widespread among all demographics. They can affect anyone - all ages, sizes, genders, sexualities, cultures and socioeconomic ranges. Experiences that make communities vulnerable, such as food insecurity, trauma, interpersonal violence, substance use, and more, have been shown to increase risk for eating disorders. Less than 20% of people affected actually receive the formal treatment they need - but people who get help are four times more likely to recover from their eating disorder, and the sooner they get help the faster they recover. That’s why awareness, early intervention, and access to support are so important. Despite being more common than breast cancer, HIV, or schizophrenia, eating disorders have so far been severely neglected in terms of awareness, research, regulatory oversight, and funding compared to other health concerns. Many people in Colorado are underserved and do not have access to any type of support to pursue recovery. Eating disorders are a public health emergency that are long past due for attention from our lawmakers. Your action will save lives.

Honorable members of this committee, my name is Katie Ney, and I am a Registered Dietitian who has worked at the inpatient, residential and partial hospitalization levels of care for over four years. I currently hold an eight-person caseload at the highest level of eating disorder inpatient care on the intensive treatment unit at Eating Recovery Center in Denver. My job is to support the nutritional stabilization and rehabilitation of my patients. This includes monitoring their labs, vitals, daily weights, daily nutrition intake and recommending the correct caloric needs and delivery of their nutrition (solid food, supplements and/or enteral feedings). This is to meet their nutrition needs, often which coincides with weight restoration. Due to the hypermetabolic status during the refeeding process, my patients have needed upwards of 5,000 kcals/day which would objectively be nearly impossible for these patients to adhere to outside of 24-hour care. The reason for this is not just the fear of food that many of my patients have, but also the ability to condense this number of kcals into a volume that, while still physically challenging, is tolerable day after day. This is done with an individualized meal plan that can include, but not limited to, a combination of nutrient and calorie dense foods and oral supplements. In addition to oral nutrition, many of my patients require tube feedings to meet their calorie needs for wt. restoration. Tube feeding and the refeeding process require 24-hour oversight, thus only appropriate and available at higher levels of care. While I support the removal of BMI as an objective unit for insurance companies to dictate levels of care, in cases where my patients are otherwise stable (labs, vitals, completing their meal plan), if they remain at a low body weight in a hypermetabolic state, a lower level of care will do them a disservice as it could limit their nutrition options (no tube feeds) and create an environment with less medical oversight, which could be dangerous. This will lead to patient harm and the likelihood of the insurance company or self-paying family to spend more in medical costs as the patient will likely be stepped back up to a higher LOC to fully weight restore OR be discharged home prematurely and significantly increase their chance of relapse.

This is a deidentified case of a recent patient at Eating Recover Center on the intensive treatment unit:

Cassie is a 27-year-old female with AN-BP. Cassie is 68" tall and admitted at 110 lbs., which is 79% IBW. The patient has a history of multiple treatment admissions with limited sustained recovery. The patient transferred from an inpatient hospital and continued their current meal plan of 2600 kcals/day. The patient was completing their meal plan 100% with the use of solid food and supplements. Over the next 11 weeks at the inpatient level of care, the patient continued to complete their meal plan 100% and accept calorie increases to this meal plan. In the first several weeks, the patient did not engage in eating disorder behaviors such as excessive movement, restriction or purging. The patient was placed on 1:1 bathroom protocol, used a body movement tracker and room searches were completed as part of program routine. Despite the containment of 24-hour care, completing 100% of meal plan, within-normal-limits labs and vitals, the patient struggled to meet wt. restoration goals. The patient was agreeable to nutrition support via a nasogastric feeding tube. The patient denied any secretive ED behaviors.

The meal plan was increased on average 300-400 kcals every 3-5 days, until eventually bringing the patient to a meal plan of 6,610 kcals/day which was 124 kcals/kg of actual body weight of 116.8 lbs. in their 9th week of treatment. For reference, most patients require 75-100 kcals/kg actual body weight to consistently meet their weekly weight restoration goal of 3-4 lbs./week. In my four years, I have only needed to exceed 100 kcals/kg for wt. restoration with less than five patients, many of which were males who were nearly or over 70". The team suspected that Cassie was struggling with secretive eating disorder behaviors but were otherwise frustrated and perplexed with the patient's extremely high meal

plan requirements. In the patient's 6th week of care, large bags of intentional vomit were found hidden in the patient's wardrobe. This behavior continued over the last half of the patient's inpatient stay. Multiple, large bags of vomit were hidden in the patient's room, on her person, in the community room and in the spa. As a result of this purging, the patient did not full weight restore and ultimately discharged from treatment at 112.6 lbs., only 2 lbs. over their admission weight. This patient has since re-admitted two more times.

Without the use of the patient's low body weight data, it is highly likely that this patient would have been recommended for a lower level of care and their purging behaviors and lack of full weight restoration would not have been resolved. This would have led to a significantly underweight human purging a large daily amount putting them at risk of significant and serious fluid and electrolyte shifts which can be fatal. It is my opinion that if BMI is not utilized in a patient's care, especially and specifically in low body weighted patients who otherwise show up "perfect on paper", this will lead to harmful limitations on patient's access to higher levels of care and increased rates of relapse.

I have devoted my professional career to supporting the recovery of patients with eating disorders who come to care in all sizes and shapes. By excluding patients with Anorexia Nervosa in ALL its presenting forms, we will inadvertently harm a specific subset of patients in need of treatment and support by decreasing their access to higher levels of care.

Therefore, I request an amendment to this bill so that that ALL forms of Anorexia Nervosa be included. Please ADD Anorexia B-P subtype and Atypical Anorexia Nervosa to the diagnoses that are excluded or simply change the language to read "Anorexia Nervosa" instead of separating out the specific subtype of Anorexia Nervosa – Restricting Subtype.