Equity Starts Here

Screening Eating Disorders in School Based Health Centers

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Continuing Education Credits

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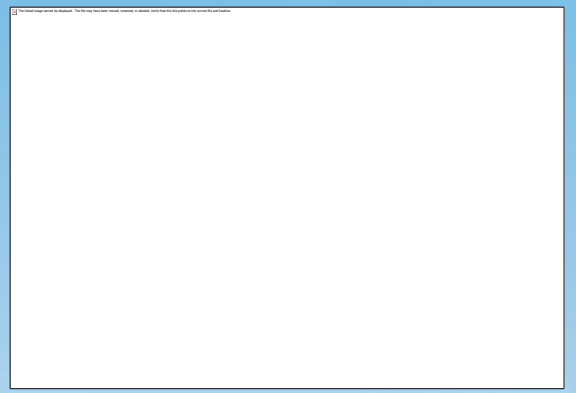

This series is intended for Dentists, Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Psychologists, Registered Dietitians, and Social Workers.

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Learning Objectives

By the end of this workshop, the participant will be able to

- Identify clinical red flags and select appropriate evidence-based eating disorder screening tools for SBHC settings
- Demonstrate trauma-informed, culturally responsive strategies to determine appropriate follow-up, monitoring and referral

Myths & Realities

(National Eating Disorders Association, n.d.; University of Rochester Medical Center, n.d.; Arcelus et al., 2011)

	MYTH	REALITY
Eating disorders can develop at any age		x
Parents cause eating disorders	x	
Eating disorders have the second highest mortality rate of any psychiatric illness behind opiate addiction		x
“Disordered pattern of eating” is a synonymous term for a clinical eating disorder	x	
Eating disorders affect mostly girls	x	
Parents are crucial to their child's recovery with an eating disorder		x
Eating disorders are a matter of vanity, or a way to get attention	x	
To avoid conflict, parents should let their child with an eating disorder eat as much or as little as they want	x	
People at a normal body weight cannot have an eating disorder	x	
Food insecurity predicts a greater risk of binge eating		x

DSM 5 Eating Disorder Diagnosis

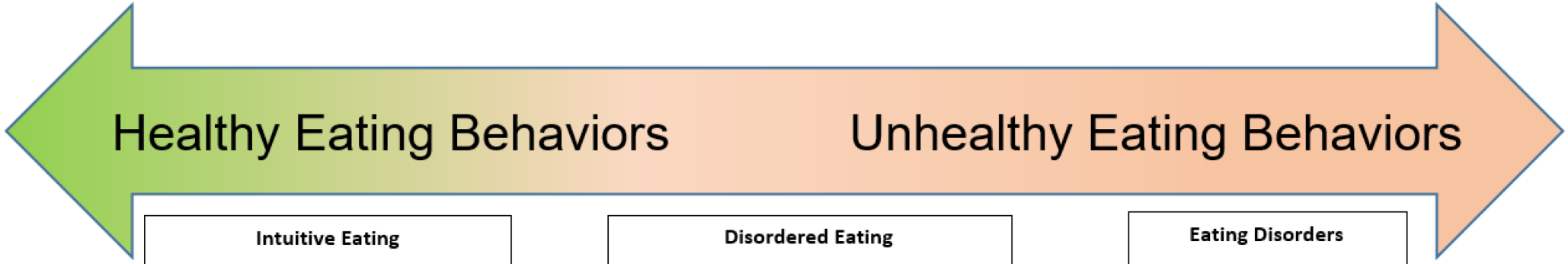
Anorexia Nervosa (AN)	•Restriction of **Energy Intake**, leading to low body weight •Intense **Fear of Weight Gain/Fatness** •**Self-evaluation highly influenced by Weight/Shape**
Bulimia Nervosa (BN)	•Recurrent **Binge Eating** •Recurrent **Compensatory Behaviours** (vomitting, fasting, excessive exercise etc) •**Self-evaluation highly influenced by Weight/Shape**
Binge Eating Disorder (BED)	•Recurrent **Binge Eating** •Marked **Distress/Guilt** about Binges
OSFED (Other Specified Feeding or Eating Disorder)	•**Mixed behaviours / presentation** •Significant impact on functioning
Atypical Anorexia Nervosa (AAN) (OSFED)	•Restriction of **Energy Intake** (body weight in a healthy range) •Intense **Fear of Weight Gain/Fatness** •**Self-evaluation highly influenced by Weight/Shape**
Avoidant/Restrictive Food Intake Disorder	•**Weight loss**, **failure to grow** or **malnutrition** with associated medical risk, as a consequence of **inadequate food intake** •Restricted eating (quantity or variety)

Avoidant/Restrictive Food Intake Disorder (ARFID)

An eating disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

- Significant weight loss
- Failure to achieve expected weight gain
- Faltering growth in children
- Significant nutritional deficiency
- Dependence of enteral feeding or oral nutritional supplements
- Marked interference with psychosocial functioning

Spectrum of Eating Behaviors



Intuitive Eating

- Eats when hungry
- Eats intentionally and with purpose
- Stops eating when satisfied/full
- Positive body image
- Includes a variety of healthy foods
- Eats a range of different foods, including indulgences at times
- Does not regulate emotions

Disordered Eating

- Restricts intake to control weight/shape
- Unresponsive to hunger/fullness cues
- Eats to regulate emotions/environment
- Compulsive eating and/or overeating
- Limited/inflexible food intake
- Firm dietary rules

Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other Eating Disorders

Disordered Eating Behaviors

MINDSHARE CONTINUUM

Preoccupation with
Food, Body & Eating

Common Pathways to Eating Disorders

Triggers

Environmental changes or trauma

Disruptions in routine (move, new environment)

Increased social media use

Social isolation (e.g., during COVID)

Emotional Impact

Fear

Anxiety

Stress

Uncertainty

Responses

Maladaptive coping to avoid difficult emotions

ED thoughts: rumination, preoccupation with weight/shape

ED behaviors: restriction, compulsive exercise, bingeing, purging

Magson, N.R., et al. (2021); Cooper, M. et al., (2020)

Risk Factors

Biological

EDO family history

Family history of mental health disorders

Hx of dieting

Low energy availability

Elevated BMI

Psychological

Perfectionism

Low cognitive flexibility

Impulsivity

Emotional dysregulation

Body image dissatisfaction

Mood disorders

Substance use disorder

Social

Being teased or bullied

Appearance ideal internalization

History of trauma

Victim of discrimination

Food insecurity

Risk Factors: Less Commonly Known

- Braces
- New diagnoses like celiac or DM
- Recent GI viral illness
- Sports
- Food insecurity

Athletes

2X risk for eating disorders

Higher rates seen in weight class sports and aesthetic sports

- 62% girls
- 32% boys

Eating Disorder Association (NEDA), 2010

LGBTQ Youth

LBGQ

- 2-6x more likely to engage in disordered eating behaviors
- Especially vulnerable to body dissatisfaction

Transgender

- Body doesn't align with felt gender identity
- Puberty: Body developing "wrong" direction
- Transphobia: Distress
- Significantly higher rates of body dissatisfaction and EDs

2025 Be Real USA NFP.

Austin et al., 2013; Romito et al., 2021

Students of Color

Different lived experience with body dissatisfaction

- Hair texture
- Skin shades

Different pathways into eating disorders

- Prejudice
- Discrimination
- Microaggressions

 Parker et al., 2022; Small & Fuller, 2020; Awad et al., 2015

Disordered Eating: other causes

Acute stress/Anxiety

Can suppress appetite by stimulating corticotropin-releasing hormone and urocortin release in the hypothalamus

Chronic Stress

Stress, anxiety and increased cortisol release (resulting from HPA axis activation) are positively correlated with cravings for high-fat, high sugar foods and may underlie emotional eating in people with BED

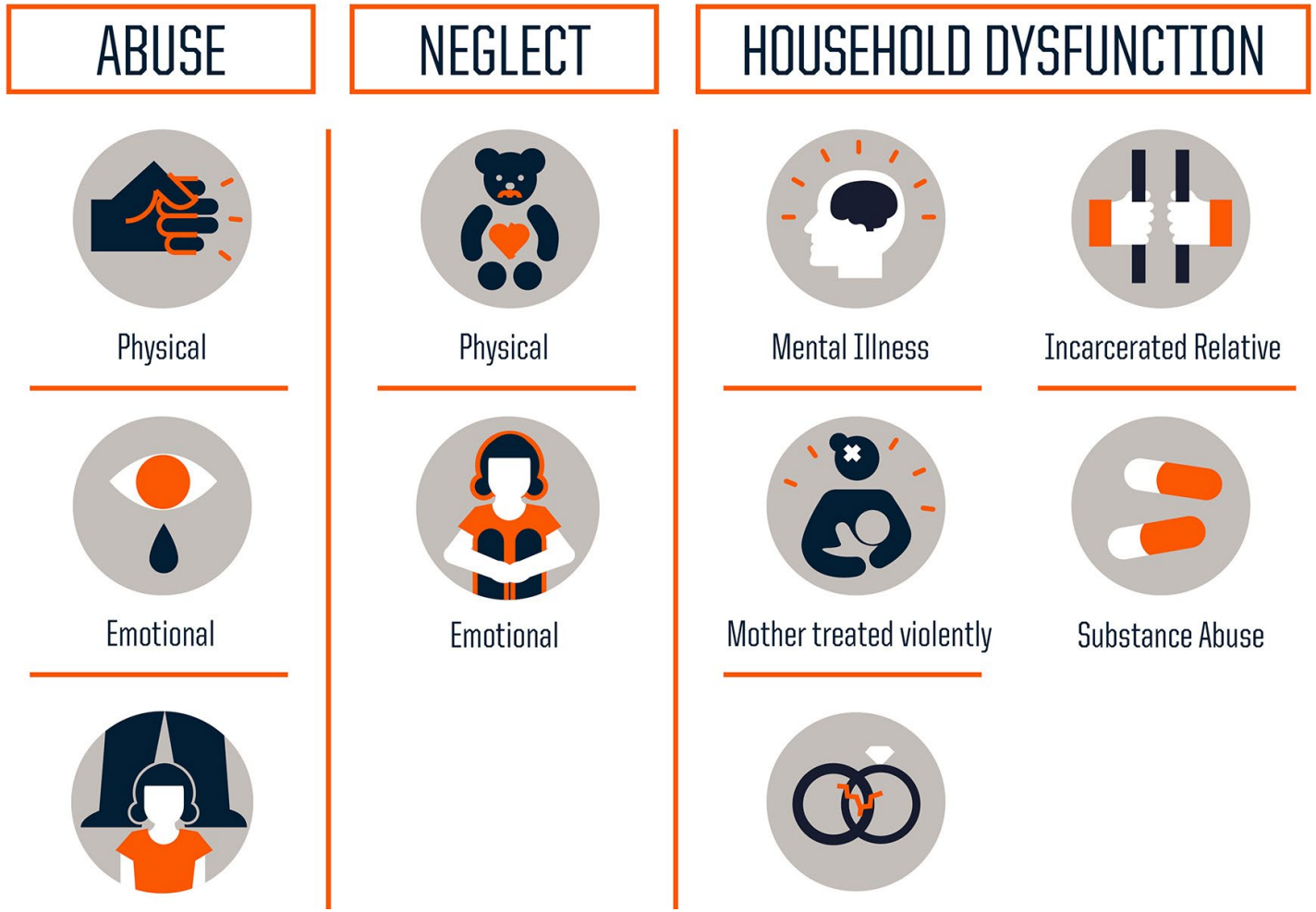
Food Insecurity

When a person does not know when they will have access to food, binge eating is potentially adaptive response when food is available

Adverse Childhood Experiences (ACEs)

- +ACEs + chronic stress=more likely to have high BMI in adulthood

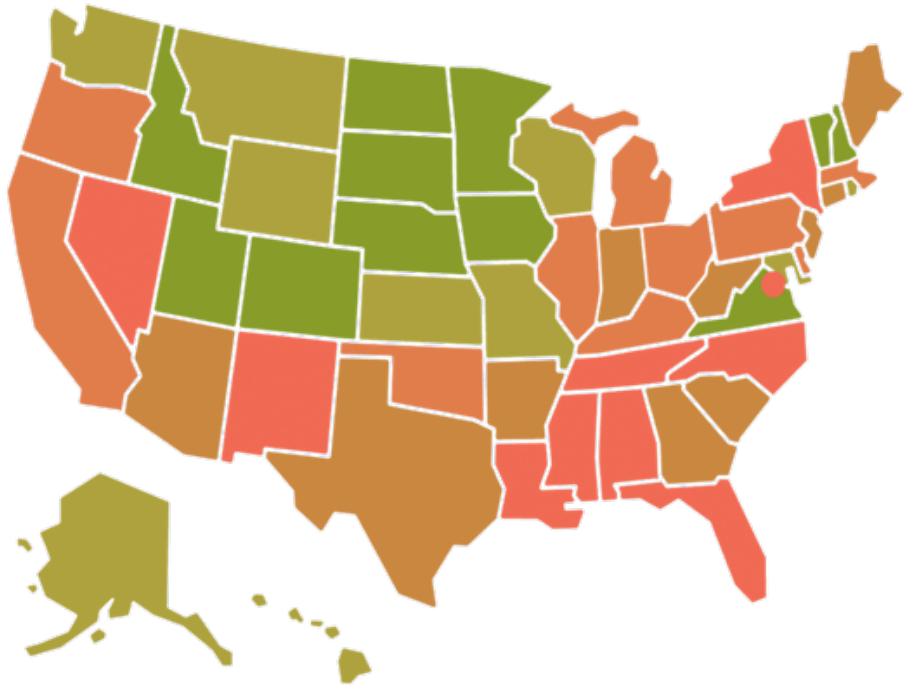
- Children with ≥4 ACEs are 2x more likely to be overweight or obese



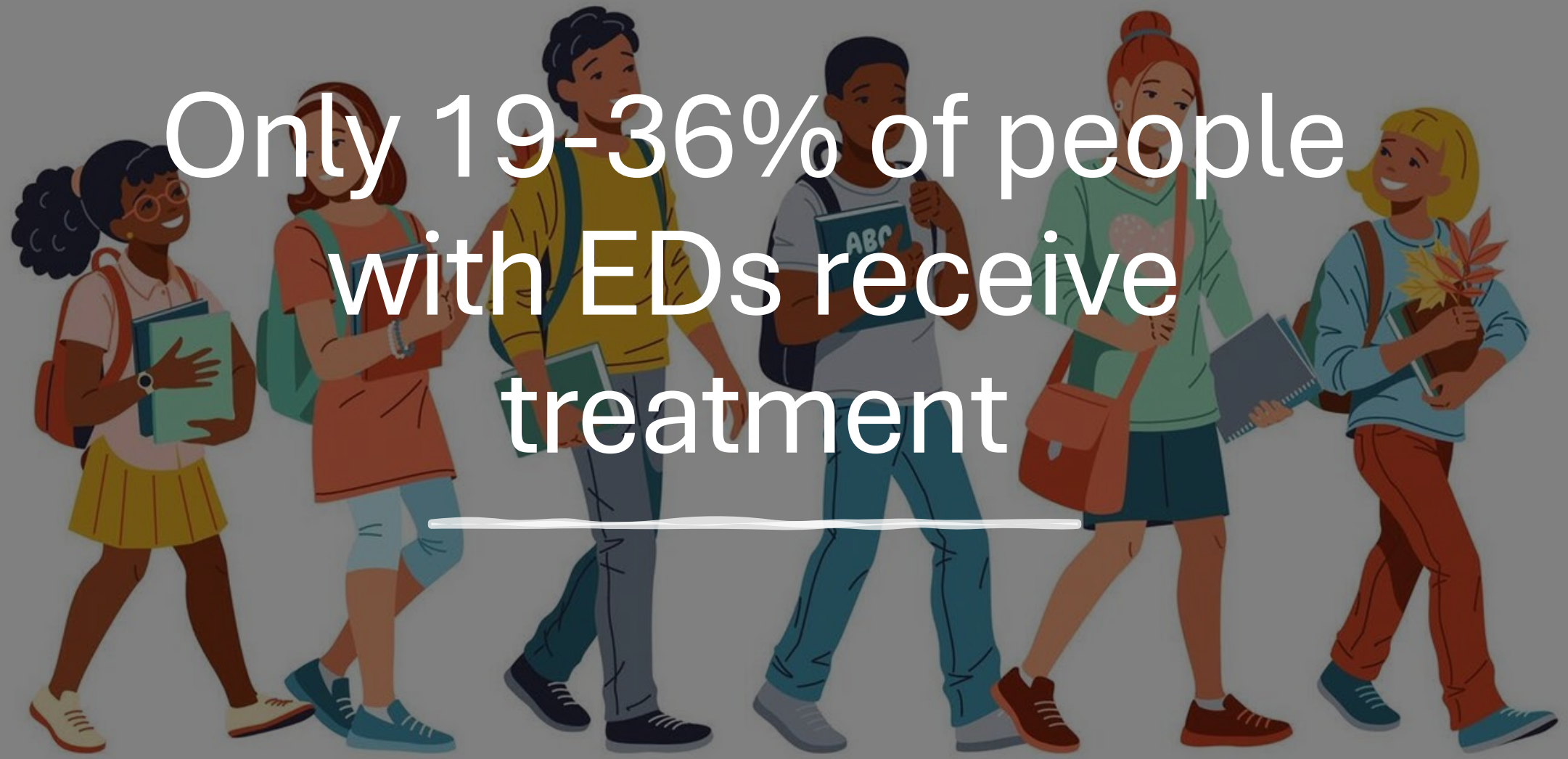
Food Insecurity

Inconsistent and unreliable access to enough nutritious food to lead a healthy life

- 1 in 6 students in the US are food insecure (post-Covid)
- Food insecure students:
  - Need to eat when food is available
  - Can lead to behaviors that may present similarly to AN on the surface but driven by the need to preserve food that is available.
  - Is associated with higher BMI likely because of the restriction and binge cycle.



Fefferman et al., 2021; United Way NCA, 2021



Only 19-36% of people with EDs receive treatment

Treatment Delays

Average delays before treatment

Restrictive anorexia 2.5 years

Binge eating disorder 6 years

Atypical Restrictive anorexia 9.2 years

Treatment Disparities Across Race and Gender

Preventative

- Minoritized racial or ethnic identities are less frequently asked by providers about eating behaviors compared to privileged identities

Assessment

- White people 2x as likely as Black or Asian people to be diagnosed/treated for EDs
- Screening and diagnosis were originally based mostly on studies of young white women, shaping understanding for decades.
- As a result, eating disorders are still often incorrectly seen as mainly affecting thin, upper-class, cisgender white women

Treatment

- Latin and Indigenous people presenting with ED symptoms are less likely than White people with similar symptoms to receive treatment referrals.
- Among men, EDs are under-recognized and under-treated, but are increasing in prevalence.

Screening

The USPSTF recommends screening for all at-risk patients

Who is “at-risk”?

- Elevated BMI
- Low BMI
- Drop in BMI during adolescent phase
- Any medical or behavioral red flags
- Any signs of disordered eating

EDO Screening Tools

- Bias and lack of awareness that can lead to missed ED diagnoses can be reduced by using validated screening tools designed for diverse populations
- Although validated, current screening tools may not adequately capture EDOs in marginalized groups
- Current screening tools are heavily focused on evaluation of AN and BN with little consideration of other EDs

ESP

Eating Disorder Screen for Primary Care

Eating Disorder Screen for Primary Care (ESP)[1]

	YES	NO
1. Are you satisfied with your eating patterns?		
2. Do you ever eat in secret?		
3. Does your weight affect the way you feel about yourself?		
4. Have any members of your family suffered with an eating disorder?		
5. Do you currently suffer with or have you ever suffered in the past with an eating disorder?		

* A "no" to question 1 is considered an abnormal response.
** A "yes" to questions 2-5 are considered abnormal responses.

Cotton et al., 2003

EDE-Q

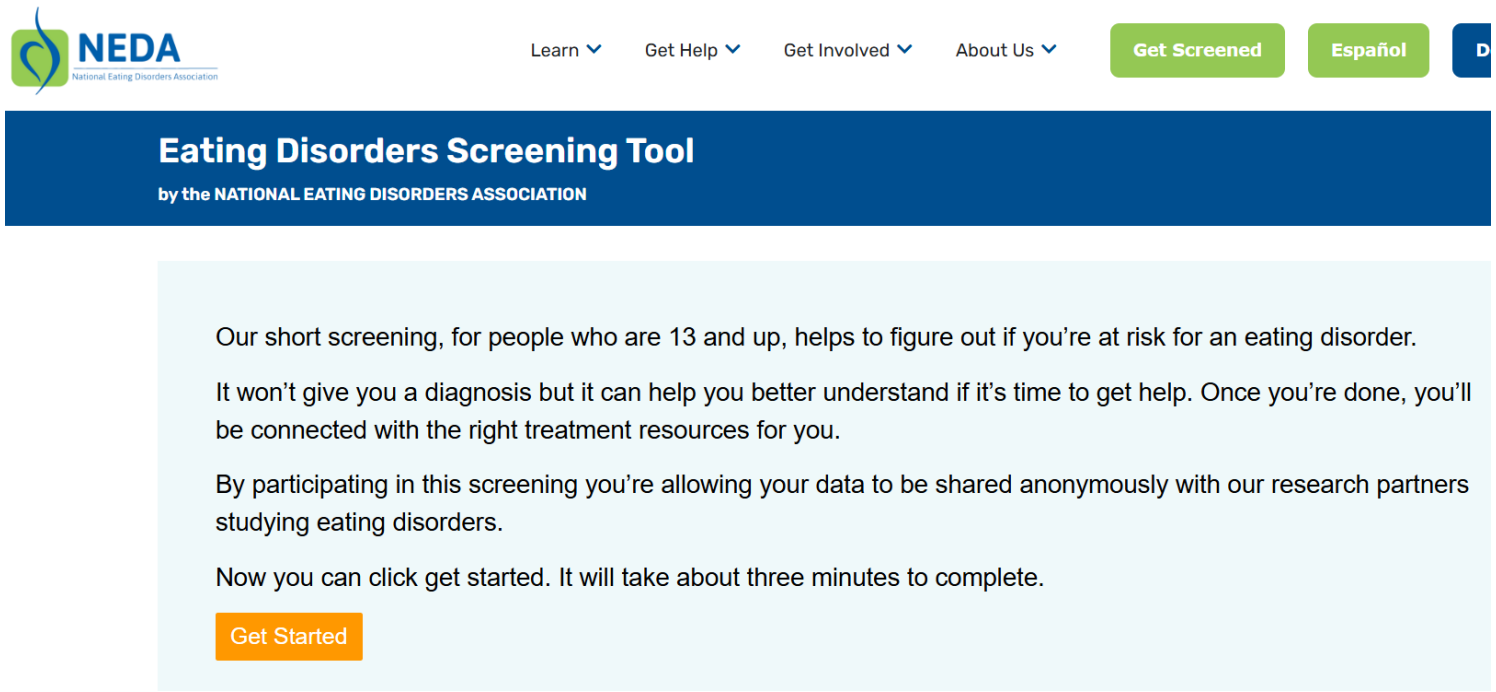
Eating Disorder Examination Questionnaire

		No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Everyday
1	Questions 1 to 12: Remember that the questions only refer to the past four weeks (28 days) only. Have you been deliberately TRYING to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
2	Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	6
3	Have you TRIED to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4	Have you TRIED to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
5	Have you had a definite desire to have an EMPTY stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	6
6	Have you had a definite desire to have a TOTALLY FLAT stomach?	0	1	2	3	4	5	6
7	Has thinking about FOOD, EATING or CALORIES made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
8	Has thinking about SHAPE or WEIGHT made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
9	Have you had a definite fear of losing control over eating?	0	1	2	3	4	5	6
10	Have you had a definite fear that you might gain weight?	0	1	2	3	4	5	6
11	Have you felt fat?	0	1	2	3	4	5	6
12	Have you had a strong desire to lose weight?	0	1	2	3	4	5	6
13	Questions 13-18: Remember that the questions only refer to the past four weeks (28 days). Over the past 28 days, how many TIMES have you eaten what other people would regard as an UNUSUALLY LARGE AMOUNT OF FOOD (given the circumstances)?							
14	On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)?							

(Fairburn & Beglin, 2008)

SWED

Stanford-Washington Eating Disorder Screen



Fitzsimmons-Craft et al., 2019

EAT-26

Eating Attitudes Test-26

Part B: Check a response for each of the following statements:		Always	Usually	Often	Some times	Rarely	Never
1.	Am terrified about being overweight.	□	□	□	□	□	□
2.	Avoid eating when I am hungry.	□	□	□	□	□	□
3.	Find myself preoccupied with food.	□	□	□	□	□	□
4.	Have gone on eating binges where I feel that I may not be able to stop.	□	□	□	□	□	□
5.	Cut my food into small pieces.	□	□	□	□	□	□
6.	Aware of the calorie content of foods that I eat.	□	□	□	□	□	□
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	□	□	□	□	□	□
8.	Feel that others would prefer if I ate more.	□	□	□	□	□	□
9.	Vomit after I have eaten.	□	□	□	□	□	□
10.	Feel extremely guilty after eating.	□	□	□	□	□	□
11.	Am preoccupied with a desire to be thinner.	□	□	□	□	□	□
12.	Think about burning up calories when I exercise.	□	□	□	□	□	□
13.	Other people think that I am too thin.	□	□	□	□	□	□
14.	Am preoccupied with the thought of having fat on my body.	□	□	□	□	□	□
15.	Take longer than others to eat my meals.	□	□	□	□	□	□
16.	Avoid foods with sugar in them.	□	□	□	□	□	□
17.	Eat diet foods.	□	□	□	□	□	□
18.	Feel that food controls my life.	□	□	□	□	□	□
19.	Display self-control around food.	□	□	□	□	□	□
20.	Feel that others pressure me to eat.	□	□	□	□	□	□
21.	Give too much time and thought to food.	□	□	□	□	□	□
22.	Feel uncomfortable after eating sweets.	□	□	□	□	□	□
23.	Engage in dieting behavior.	□	□	□	□	□	□
24.	Like my stomach to be empty.	□	□	□	□	□	□
25.	Have the impulse to vomit after meals.	□	□	□	□	□	□
26.	Enjoy trying new rich foods.	□	□	□	□	□	□

Garner et al., 1982

Children's Binge Eating Disorder Scale and Response Frequencies

TABLE 2. Children's binge eating disorder scale and response frequencies

Item	Response Choice	Number of Participants Responding yes, *N* (%)
1. Do you ever want to eat when you are not even hungry?	Yes/No	24 (44%)
2. Do you ever feel that when you start eating you just cannot stop?	Yes/No	28 (52%)
3. Do you ever eat because you feel bad, sad, bored, or any other mood?	Yes/No	34 (63%)
4. Do you ever want food as a reward for doing something?	Yes/No	26 (48%)
5. Do you ever sneak or hide food?	Yes/No	15 (28%)
6. How long have you been doing this? (transformed to wks)	—	120
7. Do you ever do anything to get rid of what you ate?	Yes/No	0 (0%)

Marcus et al., 1988

Update Your Note Template

Disordered Eating Evaluation-

EDO thoughts/behaviors:

ARFID screening:

Dietary Recall:

Describe current physical activity:

Malnutrition-related ROS:

Pertinent Past Medical History-Growth curve reviewed:

Social history- ex. Death of loved one, parent divorce, bullying

Pertinent Physical Exam - See NoShare note for weight trends

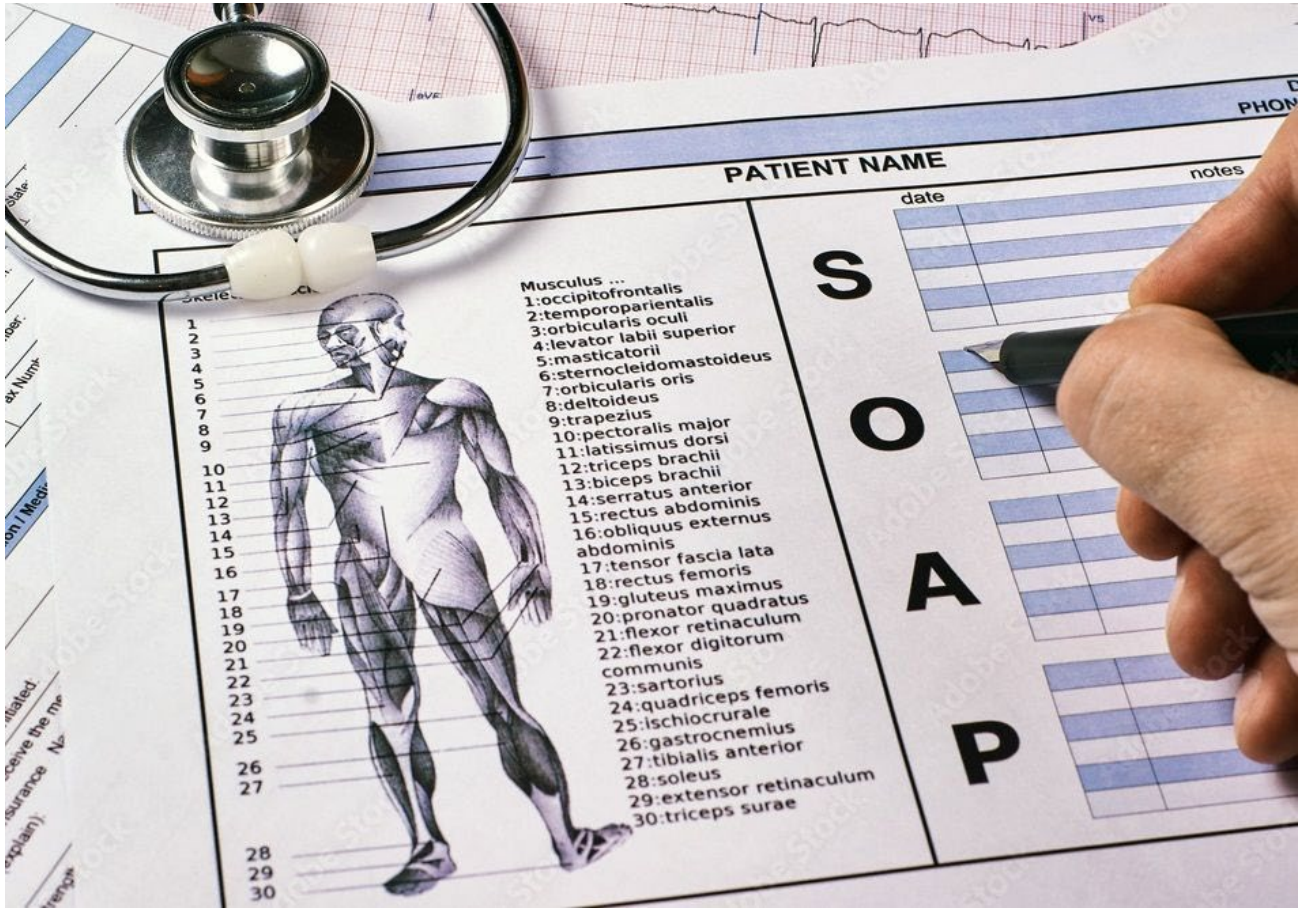
Delta P: symptomatic?

EDO Counseling/Education for Patient/Family:

Recommended level of care/Referrals

Nutrition: Meal Plan & Shakes

Exercise- contingent on nutrition completion/restricted



Your student screened positive

Determining Level of care

History reporting	**Vitals** **Physical Exam**	**Level of Care Recommendation**
Good insight & parent support Willingness to make changes & return for monitoring H/O dieting or skipping meals intermittently	Normal VS Weight changes minimal	Weekly to Monthly **SBHC Support** & Monitoring with PCP collaboration
Disordered eating habits <1200 kcal/day Lack of parent insight/support	Weight changes Normal VS	**Regular referral** to EDO medical specialist + RD + Therapist
<500 kcal/day Frequent purging through emesis Reports of SI or increased self harm	Bradycardia <60 Orthostatic hypotension Rapid weight loss >2 weeks BMI <15 adults or >10% weight loss in teens	**Urgent referral** to EDO medical specialist **within 1 week**
Syncope, chest pain, SOB, peripheral edema, acute food refusal over last 3-5 days, acute SI, psychiatric, self harm.	Bradycardia <50 Abnormal labs	**Urgent medical evaluation same day** through ED, possible admission

SBHC Management

Monitor

- Weekly-Monthly
- Sports clearance
- Blind weight
- Orthostatic VS
- Nutrition recall
- Symptom monitoring (ex. Dizziness, HA, sleep)

Refer

- Therapist
- Food pantry
- EDO Specialist

Collaborate

- PCP
- Parents
- EDO Specialist
- School

<u>Not safe to manage in SBHC setting</u>

Eating <500-800 calories/day for past 2 + weeks = at risk for re-feeding syndrome

SBHC Management: Work Up

Restriction Symptoms

Hypoglycemia ★

Bone marrow suppression; leukopenia, neutropenia, thrombocytopenia

Liver dysfunction; elevated AST/ALT

Electrolyte abnormalities

Anemia

Purging Symptoms

Low potassium ★

Low sodium and low volume status ★

Increased amylase

Most patients who purely restrict will have normal labs

Consider This

CMP, CBC w diff, Phosphate, Magnesium, Amylase & Lipase, ECG

★ = requires urgent medical attention

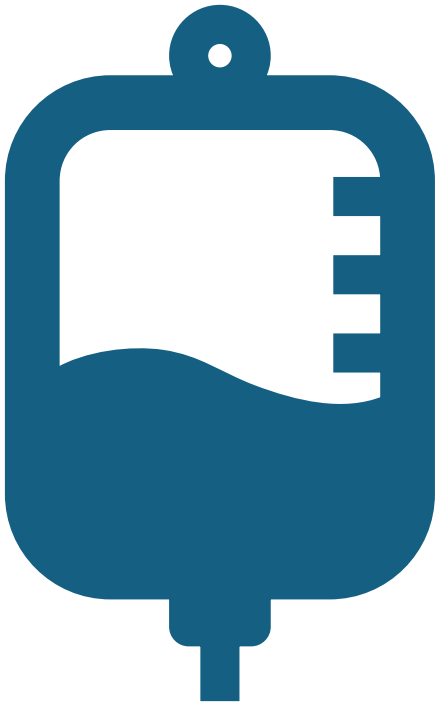
SBHC Management: Parent Involvement

Tips for Family in Recovery

- Focus on behaviors and health, not weight or appearance
- Provide consistent structure around meals and routines
- Offer calm, firm support during meals; avoid power struggles
- Encourage open, nonjudgmental communication
- Validate feelings, even if you can’t support the behavior
- Model a healthy relationship with food and body image
- Limit exposure to triggering content (diet talk, social media)
- Remove access to scales

Urgent ED Evaluation Criteria

- Purging with abnormal labs (electrolytes)
- Water loading (leading to abnormal electrolytes)
- HR <50
- Syncope with history of inadequate nutrition
- Acute food refusal (<500 calories/day for 3 or more days)
- ED with acute SI
- Hypotension
- Hypothermia
- Dehydration
- Abnormal EKG
- Shortness of breath
- Edema



Red Flags: Medical

- Bradycardia
- Amenorrhea
- Headaches
- Dizziness or syncope
- Coldness (even in warm room)
- Deviation from personal childhood growth curve

Red Flags: Behavioral

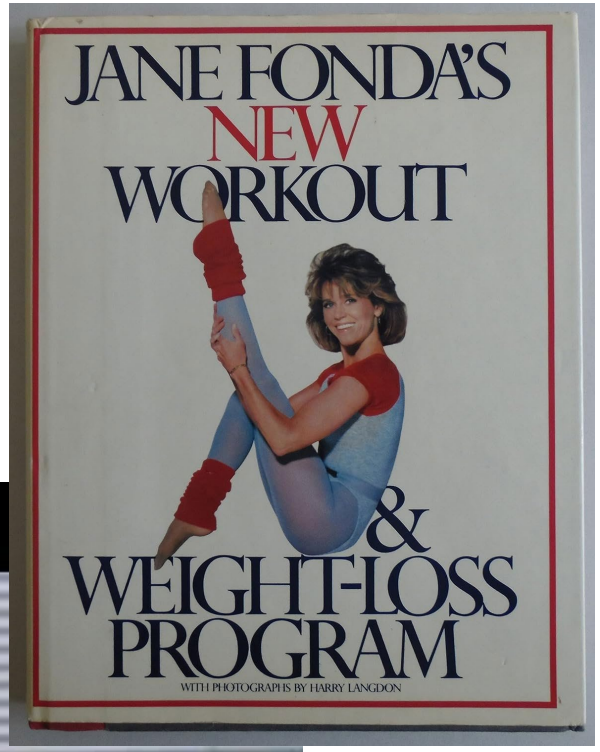
Diet Culture Across the Decades

Each generation has inherited a different version of the same conversation.

1920s: "Smoke to stay slim"

1950s: “Shake away fat”

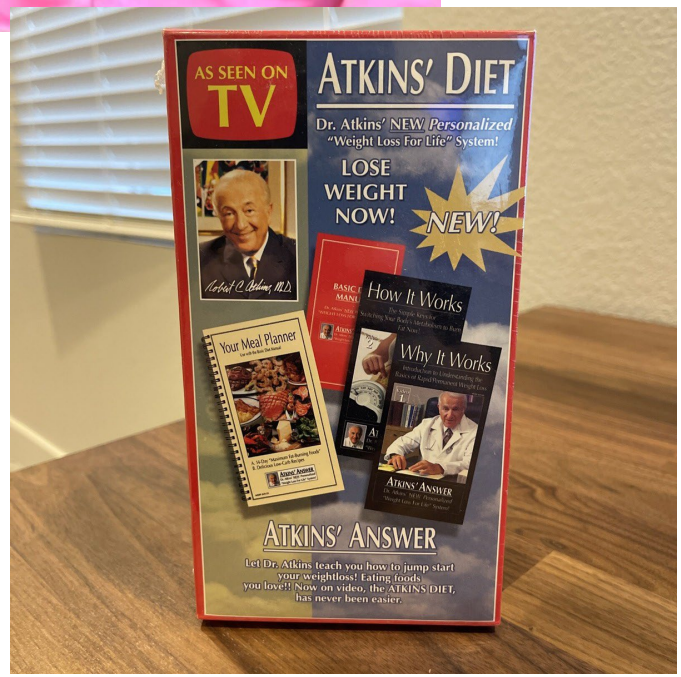
1980s: "Burn calories, earn thinness"



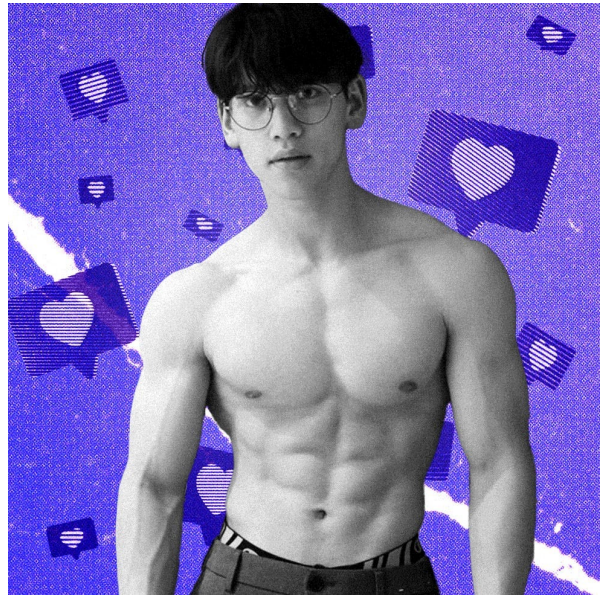
[1986 Kellogg's Special K "Pinch an inch" TV Commercial]

1990s and 2000s:
"Transform your body"

2000s



2020s “Wellness” Culture
"Optimize your health"



Red Flags: Behavioral

- Excessive or secret exercising
- New “picky” eating
- Isolated eating
- Extended meal time periods
- Eliminating an entire food group (ex. Sugar or carbs)
- New “clean” eating, cutting out gluten/dairy without medical indication
- Going entire school day without eating

Red Flags: GI + Weight Loss

- Decreased appetite
- “Not hungry”
- Belly discomfort
- Constipation
- Early fullness after a few bites
- Physical discomfort with foods previously tolerated

Red Flags: Mental Health

Anxiety

Depression

School Avoidance

Grades Dropping

Mood swings

Poor sleep

Referrals for EDO Specialists

Consult with a known local/regional eating disorder **expert** or facility or get help from a national nonprofit to find one:

- National Alliance for Eating Disorders
  www.findedhelp.com or 1-866-662-1235

Refer to a national eating disorder nonprofit resource for an eating disorder **evaluation**:

- Project HEAL
  www.theprojectheal.org/clinical-assessment

Refer to a national eating disorder nonprofit resource for **support**:

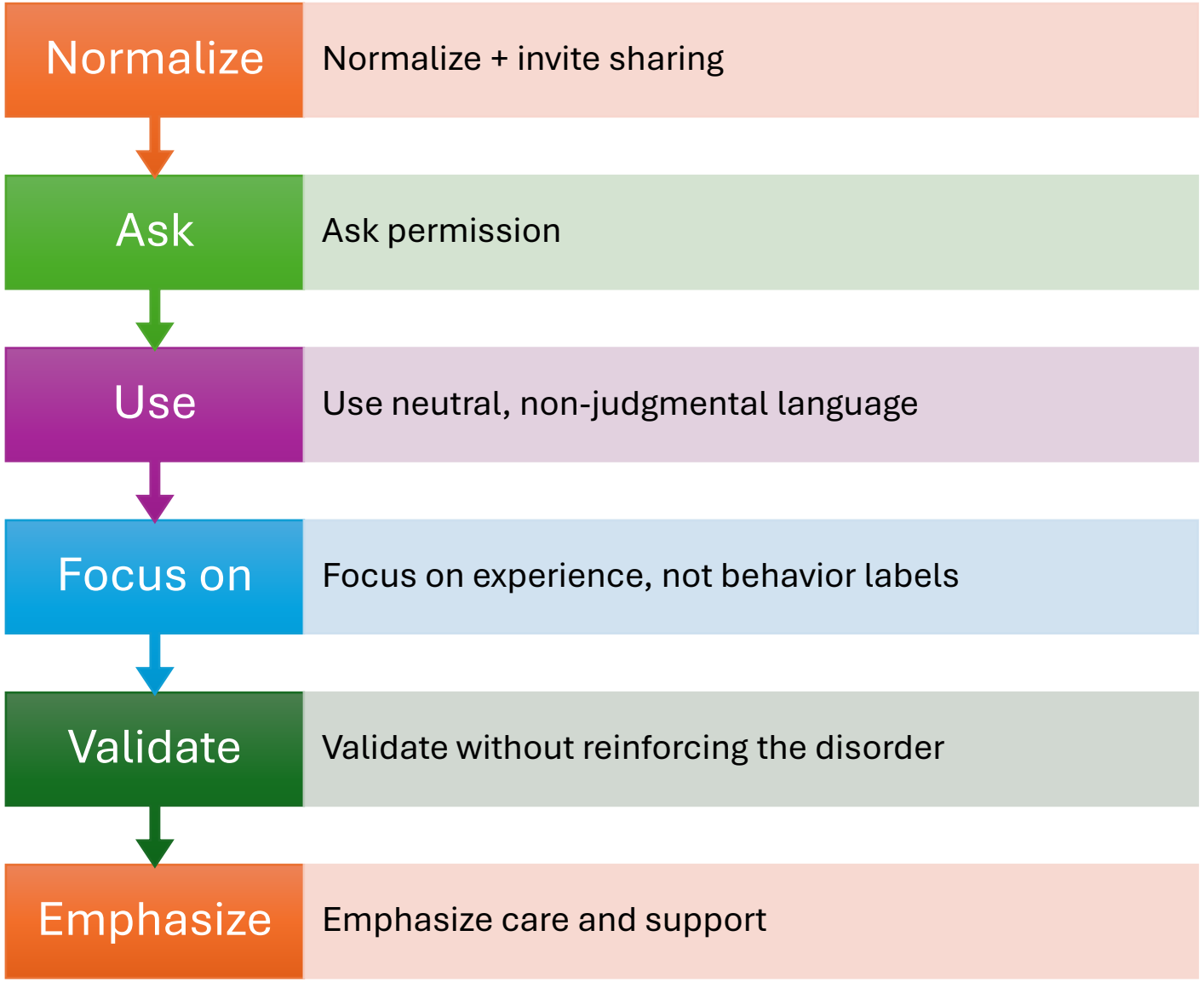
- National Eating Disorders Association (NEDA)
  www.nationaleatingdisorders.org
- National Association of Anorexia Nervosa and Associated Disorders (ANAD)
  www.nationaleatingdisorders.org/get-help/ or 888-375-7767

Refer parents for support from a national/international parent resource:

- Eating Disorder Family Support Network – Mom2Mom
  www.facebook.com/groups/EatingDisordersMom2Mom
- Families Empowered And Supporting Treatment for Eating Disorders (FEAST)
  www.feast-ed.org

From the AAP Institute for Healthy Childhood Weight Webinar Series, "Eating Disorders in Children and Adolescents" (https://tinyurl.com/2rnd898n)

Difficult Conversations



Phrases to Avoid

Numbers-focused language

- **Avoid:** “How many calories do you eat?” / “What’s your weight goal?”
- **Why:** Reinforces preoccupation and can escalate symptoms
- **Instead:** “I typically am not going to talk much about numbers; however some historical things are important. Do you know your highest weight and lowest weight you’ve been in adolescence?”

Appearance-based comments (even “positive”)

- **Avoid:** “You look healthy now” / “You don’t look underweight” / “Your BMI is normal”
- **Why:** Can invalidate or reinforce distorted body image. Even people with “normal” or elevated BMIs can have EDO
- **Instead:** “Your drop in your typical growth curve along with your physical symptoms of (ie. Dizziness) are concerning for malnutrition.

Oversimplifying or minimizing

- **Avoid:** “Just try to eat more regularly” / “You’ll be fine” / “Just don’t lose anymore weight.”/”Let’s just start you on iron supplements or vitamins”
- **Why:** Ignores complexity of eating disorders
- **Instead:** Discuss your plan and regular follow up recommendations out of concern for their overall health.

What Patients May Be Thinking → How to Respond in the Moment

Minimize / "Not sick enough"
→ "What you're going through matters—there's no threshold for deserving help."

Denial / "I don't have a problem"
→ "I hear that—can I share what I've noticed and why I wanted to check in?"

Shame / "This is my fault"
→ "That sounds really heavy—this isn't about blame."

Fear of losing control
→ "That is super normal for the eating disorder side of your brain to worry about losing control, but in reality, we want to help you gain back control that it's taken from your life."

Desire for quick/simple answers
→ "There's no one simple fix, but we can take this step by step."

Fear of weight gain
→ "That fear is really common—we can talk through it at your pace." "Our focus is on helping your body and mind feel stronger and more supported—not rushing anything without talking it through." *Do not make any comments on how much they will or won't need to gain during recovery*

Family conflict (anger + desire for understanding)
→ "It makes sense to feel both—we can figure out how to help you feel heard."

Anger toward provider
→ "It's okay to feel angry—this is hard, and I'm here to listen."

Referral Phrases

Hospital Admission/Urgent Evaluation

“Your HR is dangerously low and puts you at risk for heart attack or death. We need you medically evaluated today for your safety.”

Referral to EDO Specialist

“The specialist will not be forcing you to do anything that day (unless there are safety issues). The team will offer recommendations for you and your parents to review and use to decide on a plan together.”

Close Monitoring in SBHC

“Your physical exam and symptoms are showing signs of malnutrition. I’d like us to set some small goals together to slowly increase your nutrition. We can best monitor how your body reacts by meeting monthly in the clinic. “

Case Studies

- Brief scenario will be shown
- Use the QR code to vote on what you would do next.
- Discuss case together.
- Supportive language will be demonstrated for each scenario.

Case Study #1

- A female teen in a larger body presents to your SBHC
- There is concern about ongoing weight gain
- BMI 95%

After further discussion, you learn:

Screening tool option: BED Scale

She often restricts intake during the day, then eats large amounts of food most evenings

Eats quickly and feels out of control

Feels guilty afterwards

Reports feeling ‘ravenous’ at night after skipping breakfast and lunch

Uses eating in the evening to cope with stress and ‘shut her brain off’

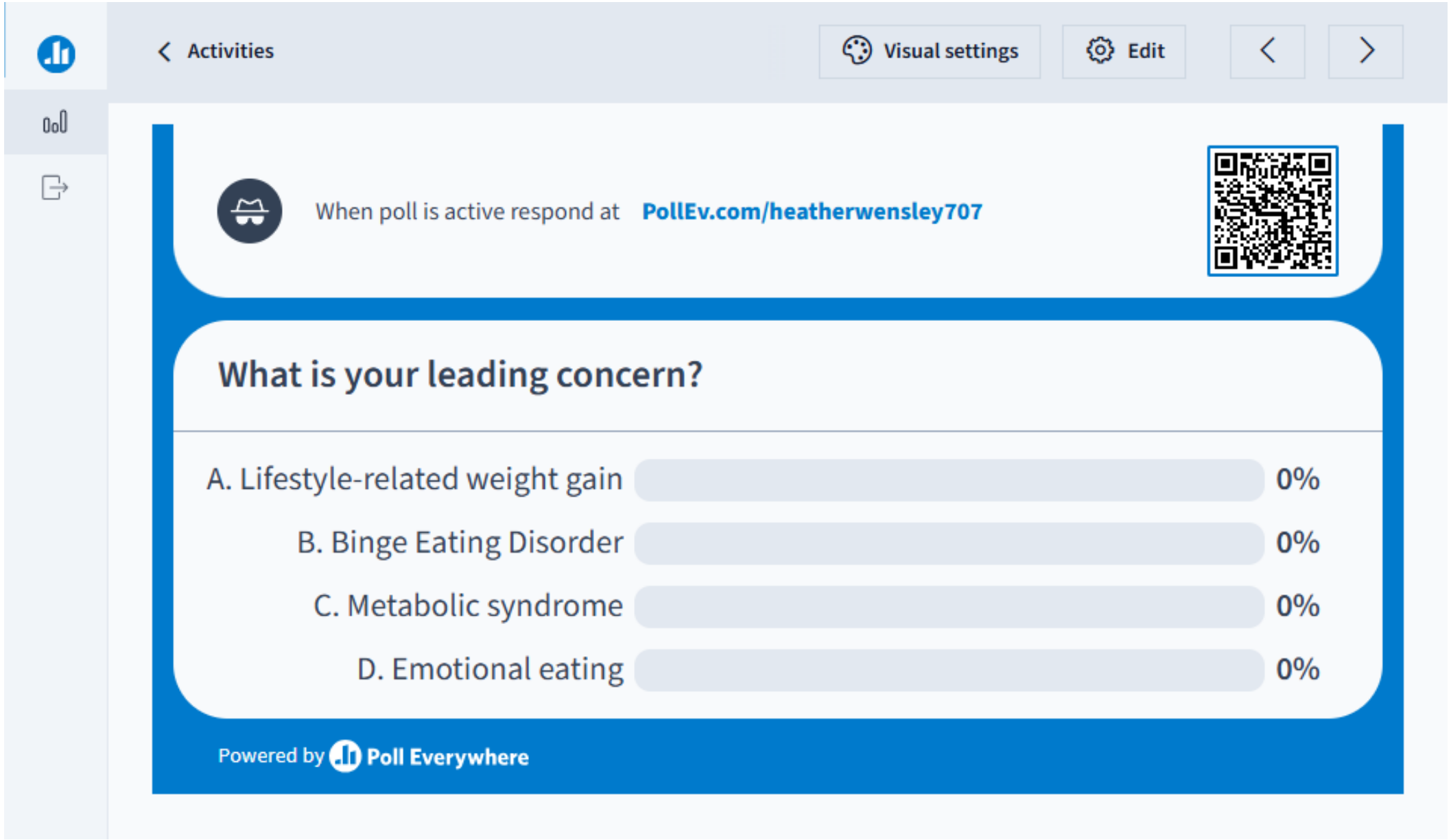
Avoids the school cafeteria due to discomfort eating around peers

Lives in a home where meals are inconsistent and food availability varies

Has a history of significant stress at home and ongoing anxiety symptoms

Mother comments often on her weight and that she eats too much

Describes trying to follow strict food rules during the day, then ‘losing control’ at night


Activities
Visual settings
Edit
When poll is active respond at PollEv.com/heatherwensley707
What is your leading concern?
A. Lifestyle-related weight gain 0%
B. Binge Eating Disorder 0%
C. Metabolic syndrome 0%
D. Emotional eating 0%
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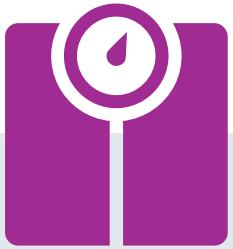
What’s driving the binge?



What we often see

Overeating

Poor self-control

Unhealthy habits

Weight gain

Actual behavior drivers

Biological

Psychological

Environmental

Trauma & Stress

How do you respond in this visit?

Binge Eating Disorder: First-line Interventions in SBHC

- **1. Normalize & Reframe**
- “This pattern is common when the body isn’t getting enough during the day.”
- Emphasize: binge eating is not a failure of willpower
- Frame as a biological + emotional response, not just a behavior

- **2. Stabilize Nutrition First (Foundational Step)**
- Encourage 3 meals + 1–3 snacks daily
- Prioritize eating earlier in the day (even if small at first)
- Reduce long gaps without food (>3–4 hours)
- Avoid prescribing dieting or restriction
- *Simple script:*
  → “The goal right now isn’t to eat perfectly—it’s to eat *consistently*.”

- **3. Address the Binge Cycle Directly**
- Explain restriction → binge cycle in simple terms
- Encourage permission to eat regularly (including previously “forbidden” foods)

Binge Eating Disorder: First-line Interventions in SBHC

- **4. Build Alternative Coping (Without Removing Food Yet)**
- Validate that eating is currently serving a purpose
- Gently introduce additional coping tools for evenings:
  - Distraction (TV, calling a friend, hobbies)
  - Sensory strategies (shower, music)
  - Emotional expression (journaling, texting someone safe)

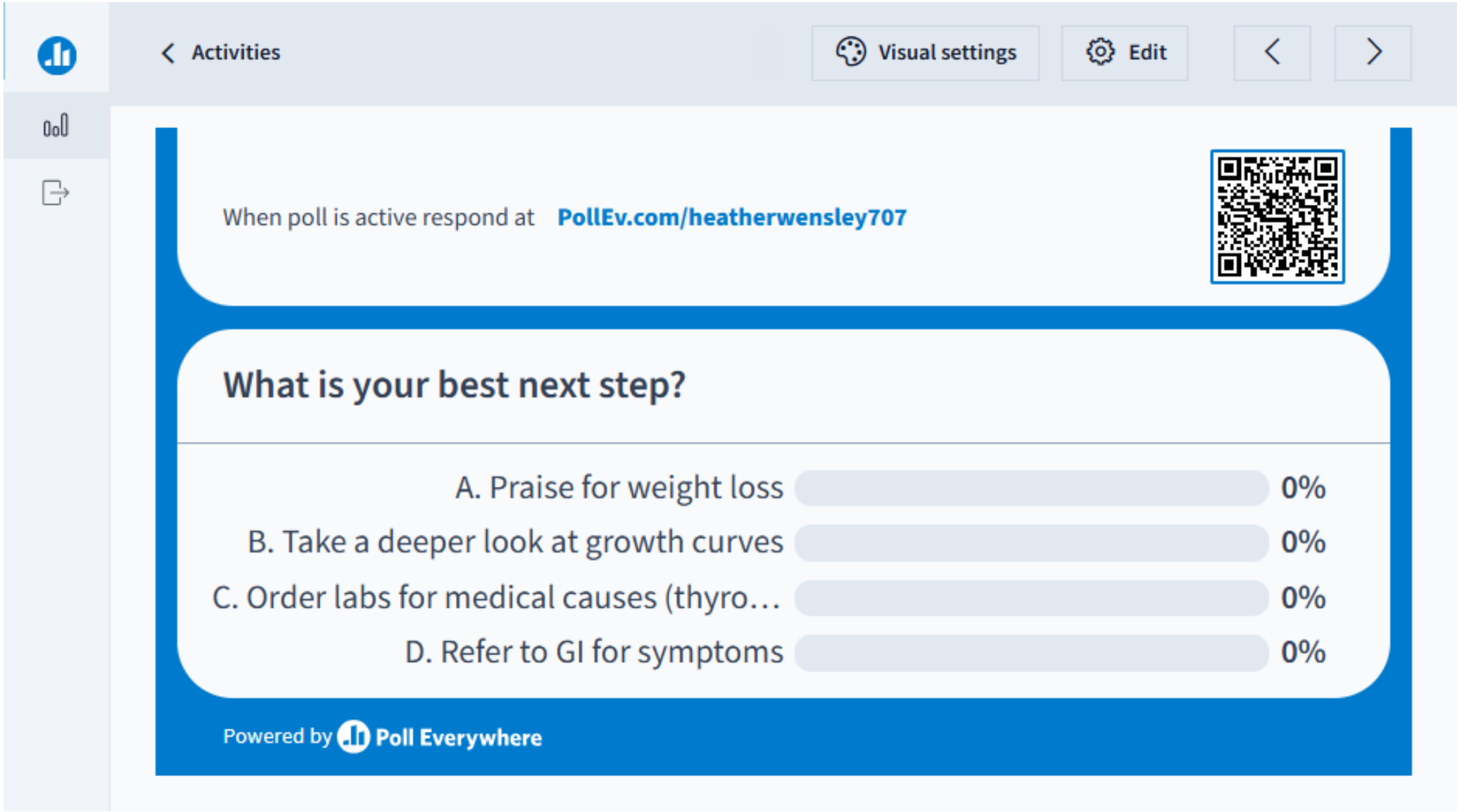
- **5. Improve Structure & Environment**
- Problem-solve school-day eating (portable breakfast, snacks)
- Explore safe, consistent access to food

- **6. Address Co-Occurring Concerns**
- Screen and begin management for:
  - Anxiety / depression
  - Sleep issues
  - ADHD or impulsivity
- Review medications that may impact appetite

Case Study #2

- A 16-year-old male presents for an annual well visit in your SBHC.
- He has a history of BMI around the 75-85th percentile.
- Today, his BMI is at the 40th percentile.

- On review of systems, he reports:
- Headaches
- Constipation and nausea with meals for the past 6 months


Activities
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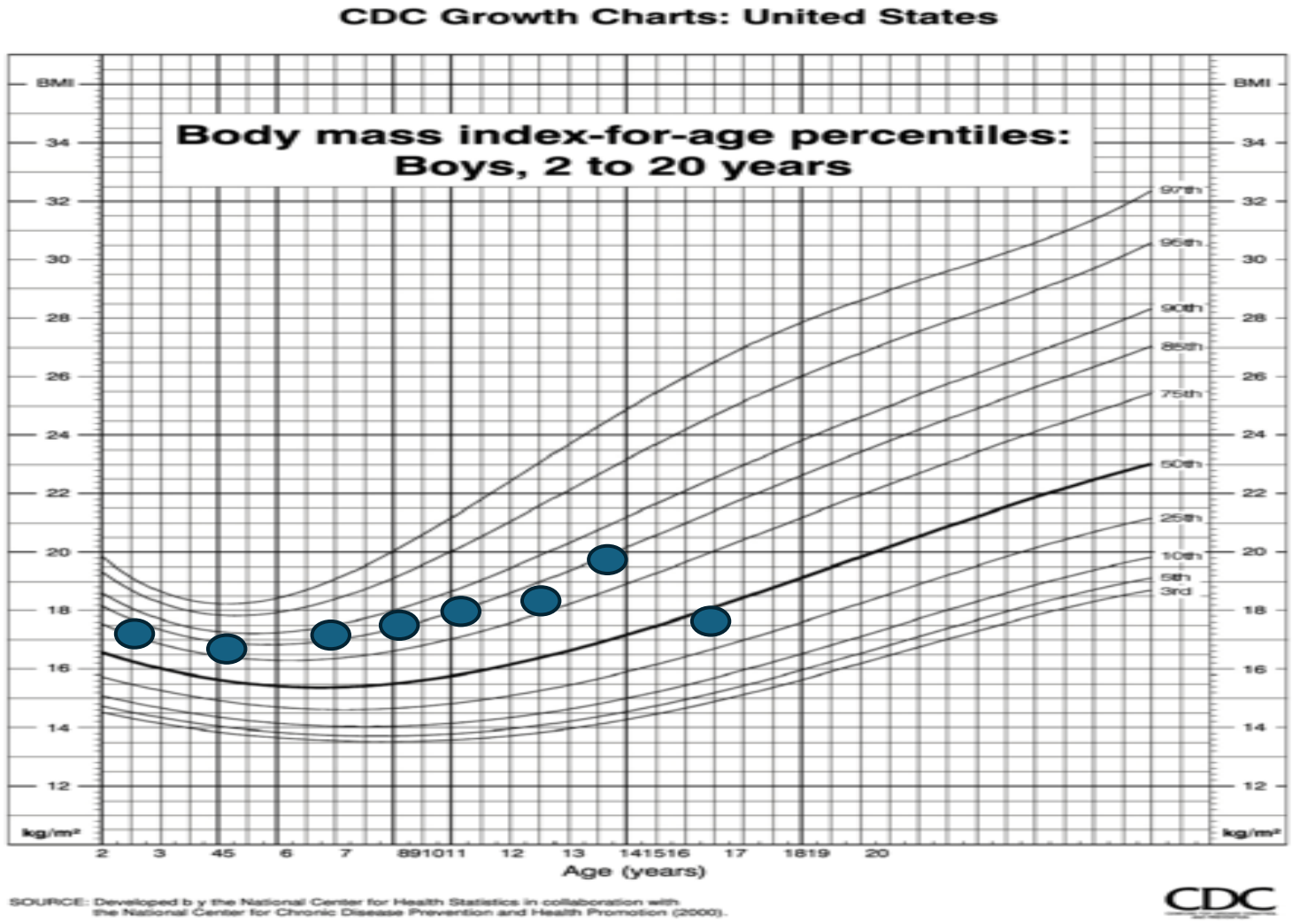
When poll is active respond at PollEv.com/heatherwensley707
What is your best next step?
A. Praise for weight loss 0%
B. Take a deeper look at growth curves 0%
C. Order labs for medical causes (thyro… 0%
D. Refer to GI for symptoms 0%
Powered by Poll Everywhere

Growth Curve Review

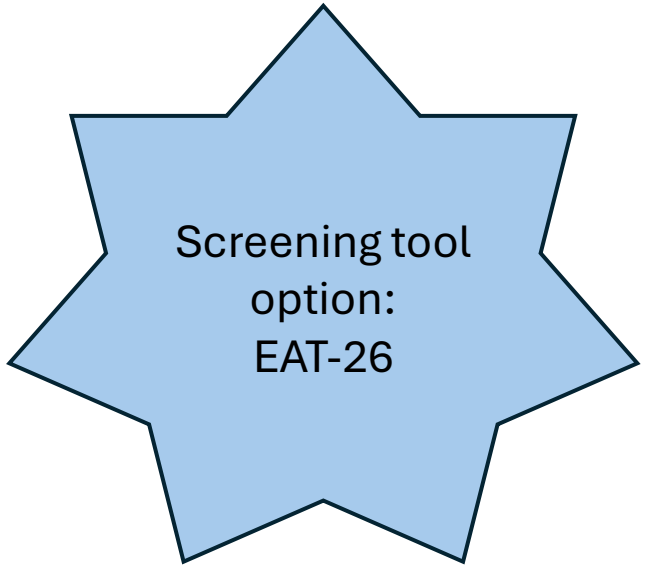
Vitals:
HR 58 BP 100/72
Delta P: 30

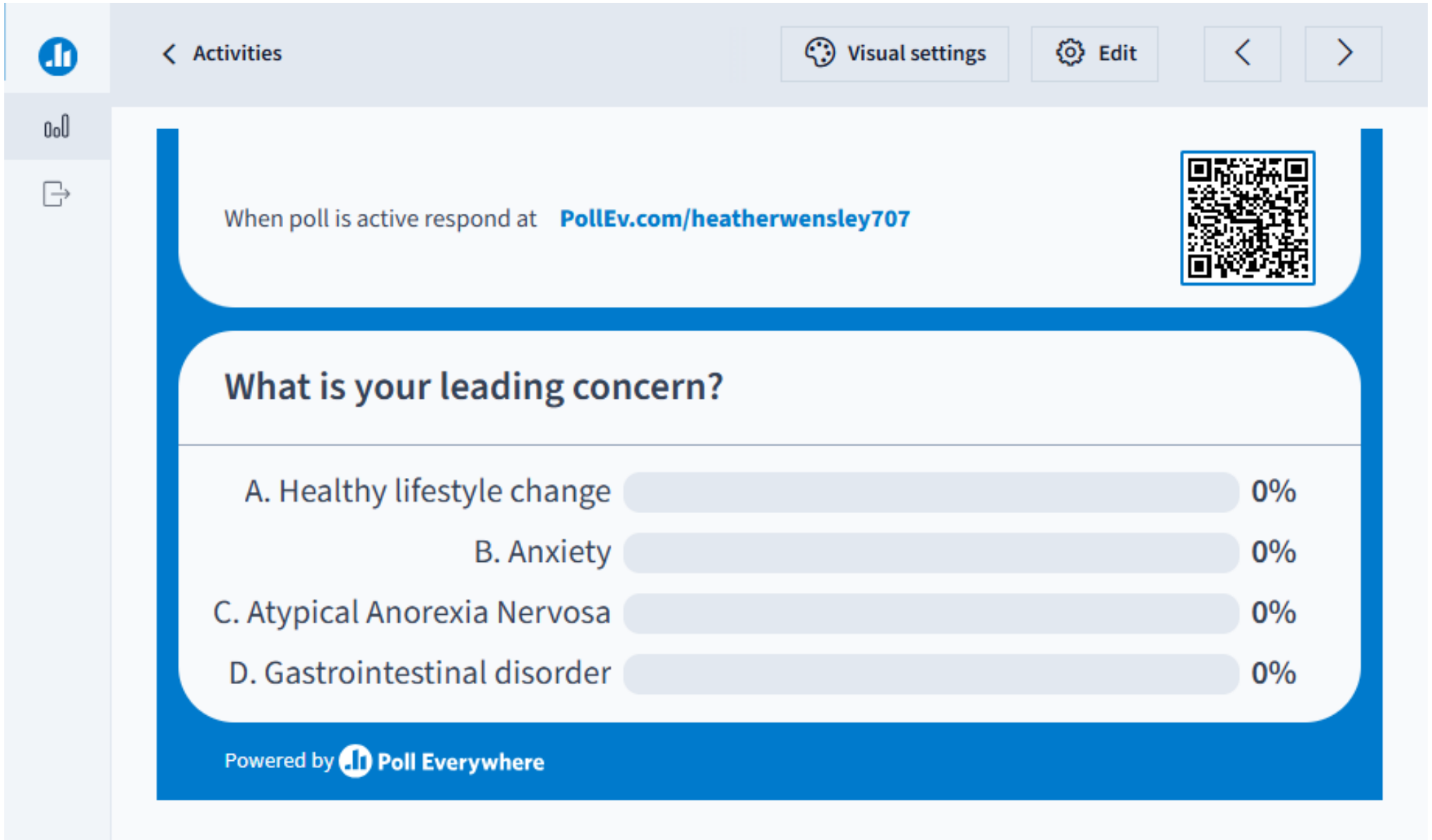
Exam:
Hands and feet cool to touch, cap refill ~2 seconds
Otherwise stable exam



On further discussion:

Intentional 40 lb weight loss over 1 year	No longer eats with family	Avoids most previously preferred foods
Primarily eats fruits, vegetables, and protein shakes	Notes he used to be “chubby and got made fun of” but now he’s comfortable with his weight	Sleep changes
Mood changes (anxiety)	Dizziness on standing most days but no syncope	Fatigue and coldness




Activities
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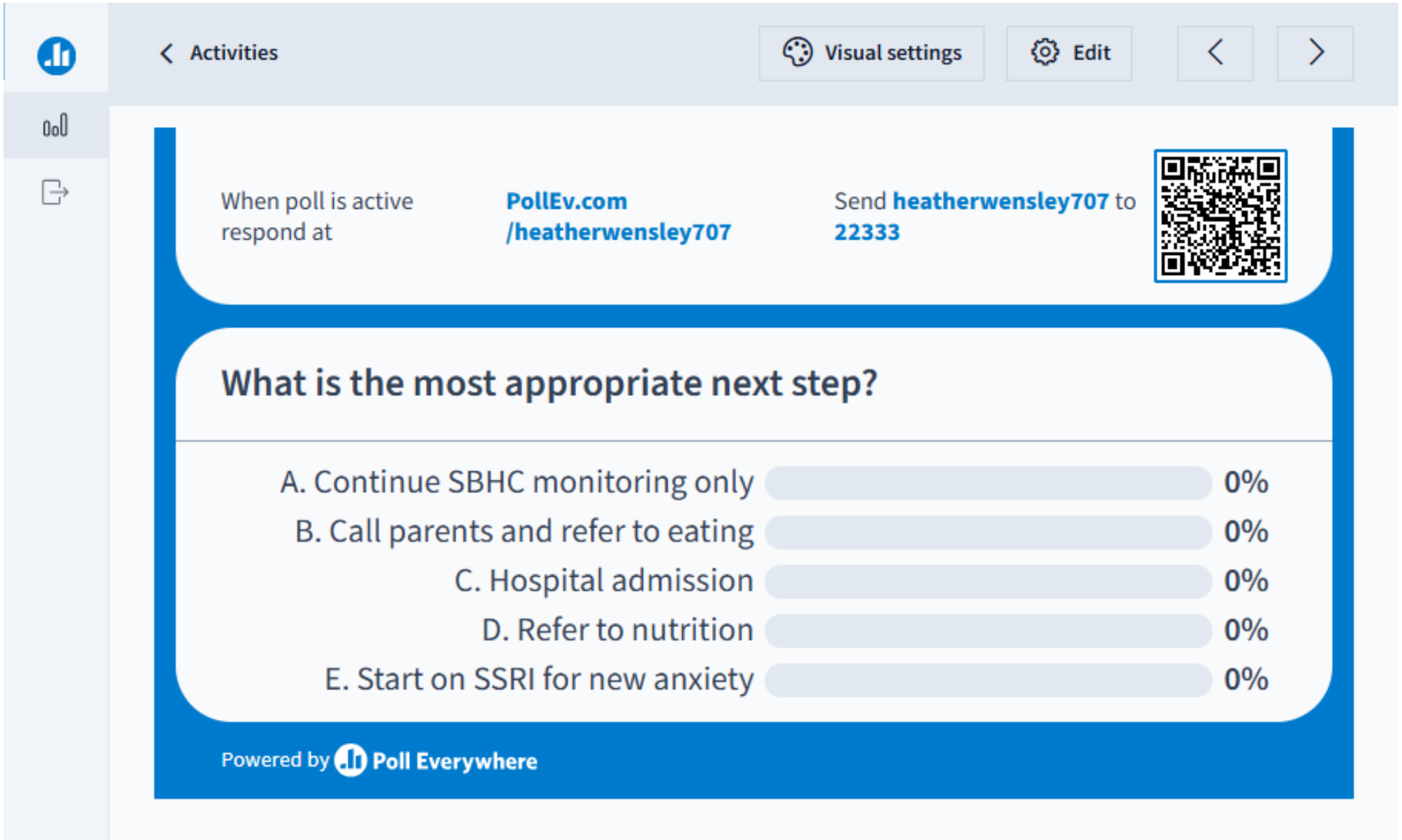
Edit
When poll is active respond at PollEv.com/heatherwensley707
What is your leading concern?
A. Healthy lifestyle change 0%
B. Anxiety 0%
C. Atypical Anorexia Nervosa 0%
D. Gastrointestinal disorder 0%
Powered by Poll Everywhere


Activities
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When poll is active respond at
PollEv.com /heatherwensley707
Send heatherwensley707 to 22333
What is the most appropriate next step?
A. Continue SBHC monitoring only 0%
B. Call parents and refer to eating 0%
C. Hospital admission 0%
D. Refer to nutrition 0%
E. Start on SSRI for new anxiety 0%
Powered by Poll Everywhere

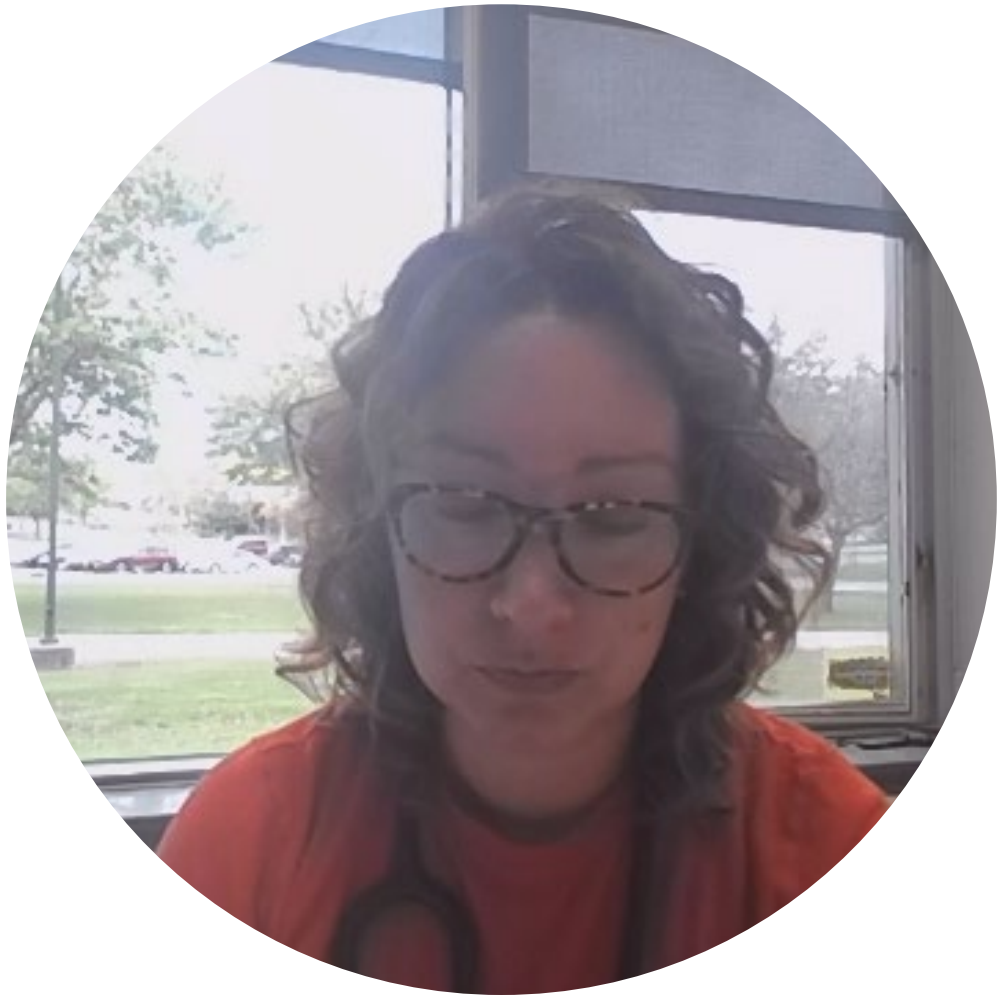
How do you respond in this visit?

SBHC Support while waiting for EDO Specialist Referral

- Weekly Monitoring (blind weights, vitals)
- Coordination with PCP
- Bridging care
- Refer to specialist (urgent vs routine)
- Communication with specialist
- Engage family early
- Letter to coach- if pausing sports until evaluation
- Use caution with starting SSRI for anxiety

Blind Weight Discussion

How to explain the rationale behind this.



Case study #3

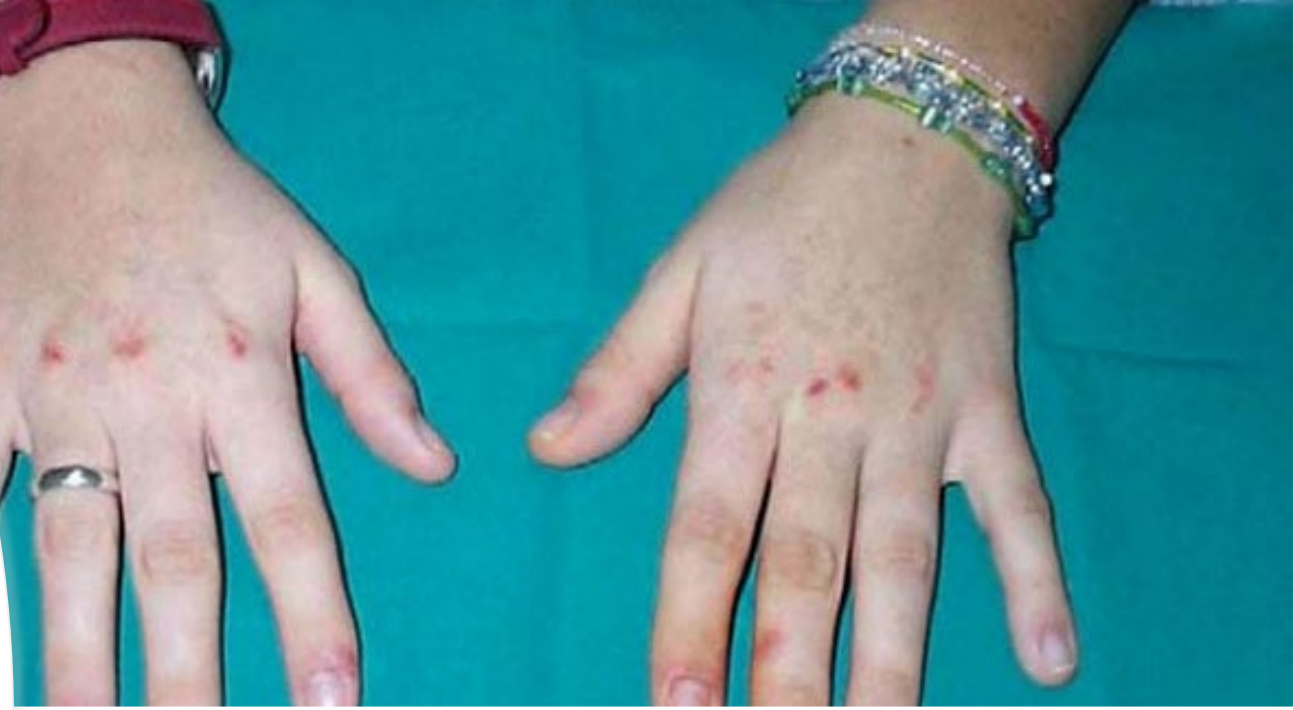
You're seeing a 17-year-old female in your school-based health center. She has had a BMI around the 80th percentile most of her life.

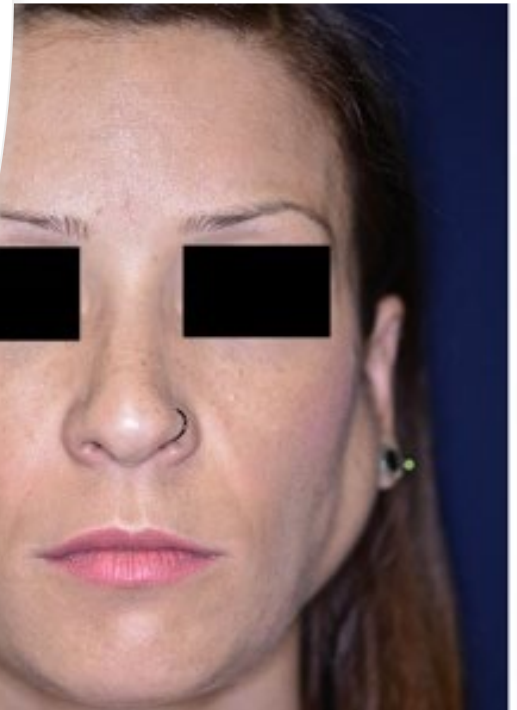
She presents with:

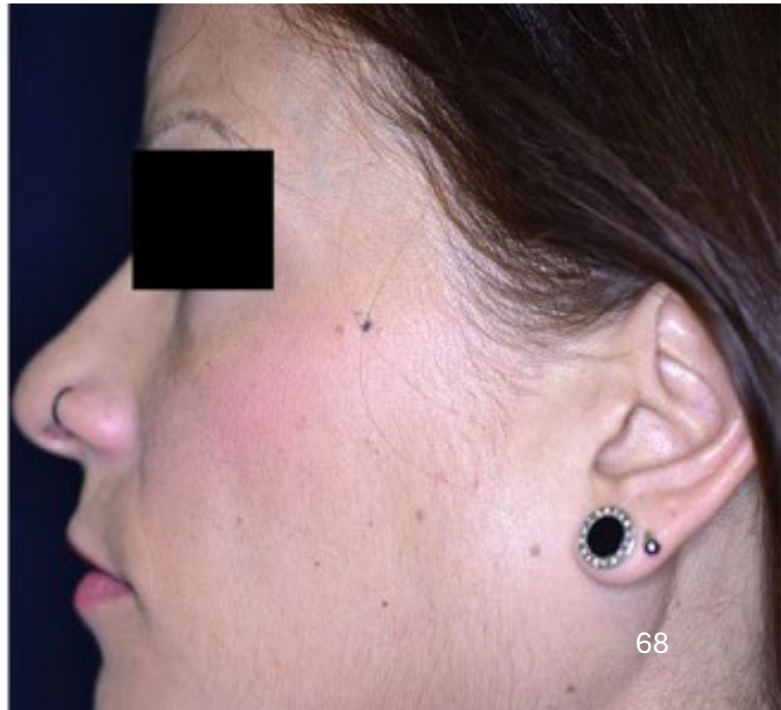
- Frequent abdominal pain
- Constipation
- Dizziness and fatigue

On exam you note:

- Calluses on the hands
- Dental enamel erosion
- Bilateral cheek fullness ('chipmunk cheeks')
- Vital signs WNL today
- Weight stable, minimal changes





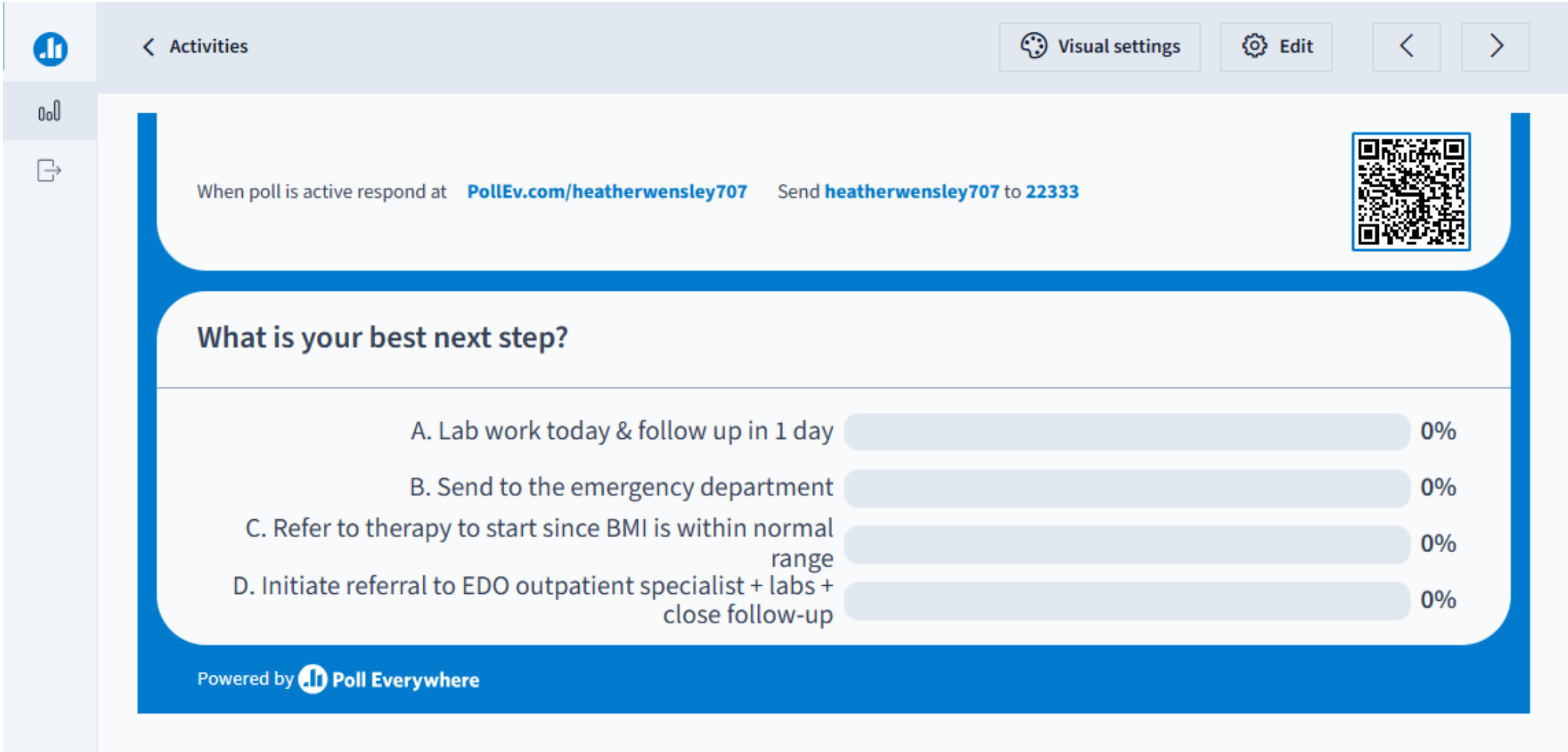


You ask about eating behaviors using a screening approach. She reports:

Purging (self-induced vomiting) 4 times per week for 3 months

Binge eating about 2 days per week

Poor body image and desire to be thinner


Activities
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When poll is active respond at PollEv.com/heatherwensley707 Send heatherwensley707 to 22333
What is your best next step?
A. Lab work today & follow up in 1 day 0%
B. Send to the emergency department 0%
C. Refer to therapy to start since BMI is within normal range 0%
D. Initiate referral to EDO outpatient specialist + labs + close follow-up 0%
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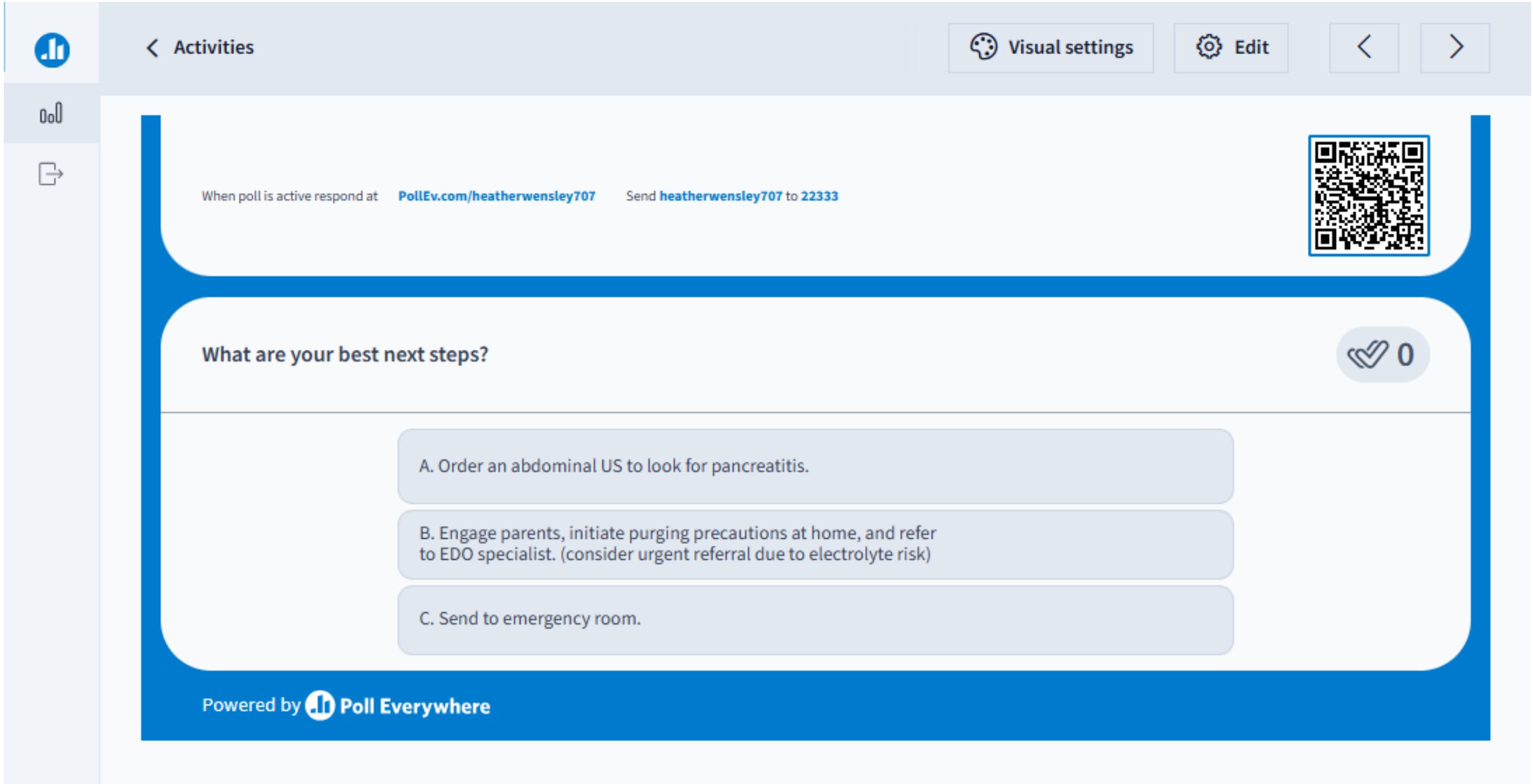
Lab Results

- CMP normal
- CBC normal
- Lipase normal
- Amylase- elevated


Activities
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When poll is active respond at PollEv.com/heatherwensley707 Send heatherwensley707 to 22333
What are your best next steps?
0
A. Order an abdominal US to look for pancreatitis.
B. Engage parents, initiate purging precautions at home, and refer to EDO specialist. (consider urgent referral due to electrolyte risk)
C. Send to emergency room.
Powered by Poll Everywhere

How to talk with parents about labs, referral, & purging precautions support at home

Case Study #4

A 13-yo female with a normal BMI presents frequently to your SBHC for headaches—usually around 1–2pm.

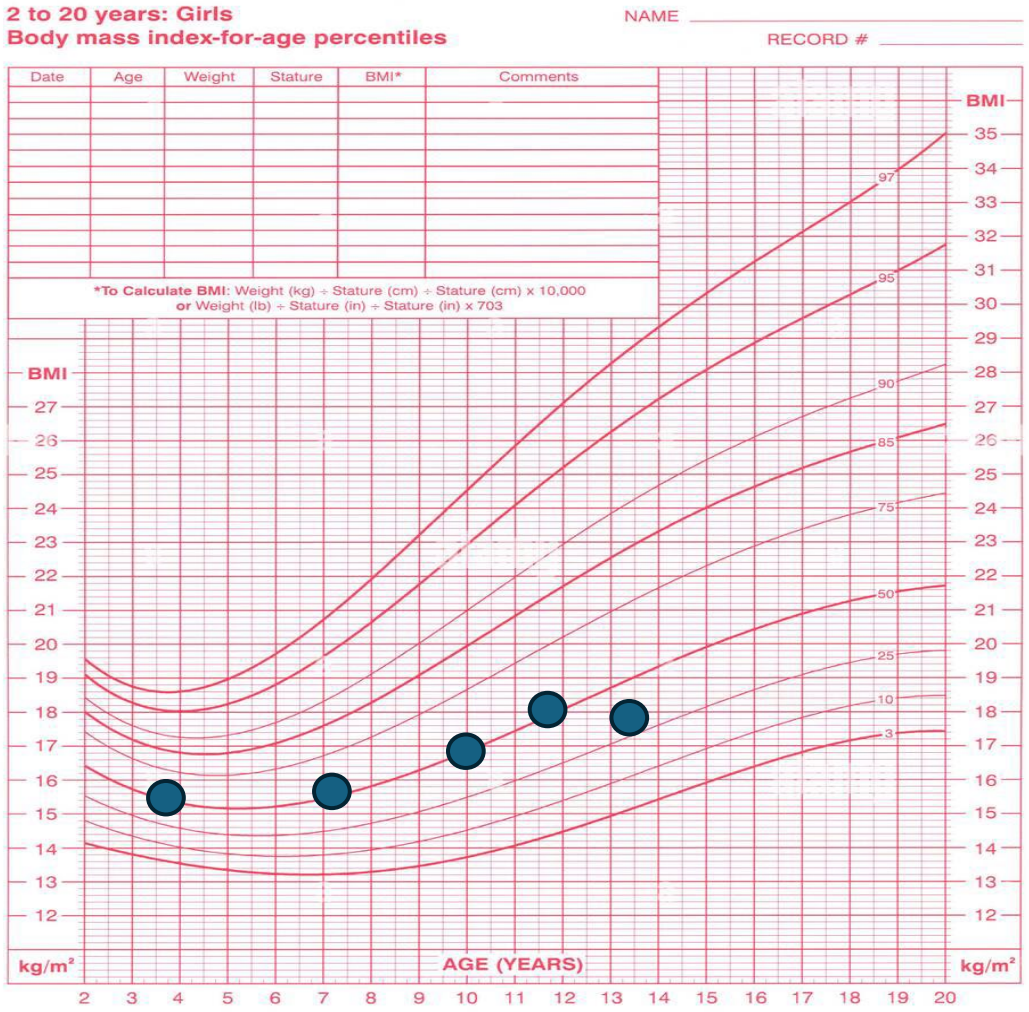
You've already ruled out:

- Sleep issues
- Stress or major life changes
- Vision concerns
- Migraine history

Vitals today are stable

- HR 85
- BP 118/78
- Delta P: 12

Growth curve



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www.alamy.com

On further discussion:

Screening tool option: ESP or SWED

They skip breakfast and lunch most days (rushed and hates school food)

Have had some weight loss over the past 2 years (~5 lb)

Say it's *not intentional* and denies any body image concerns.

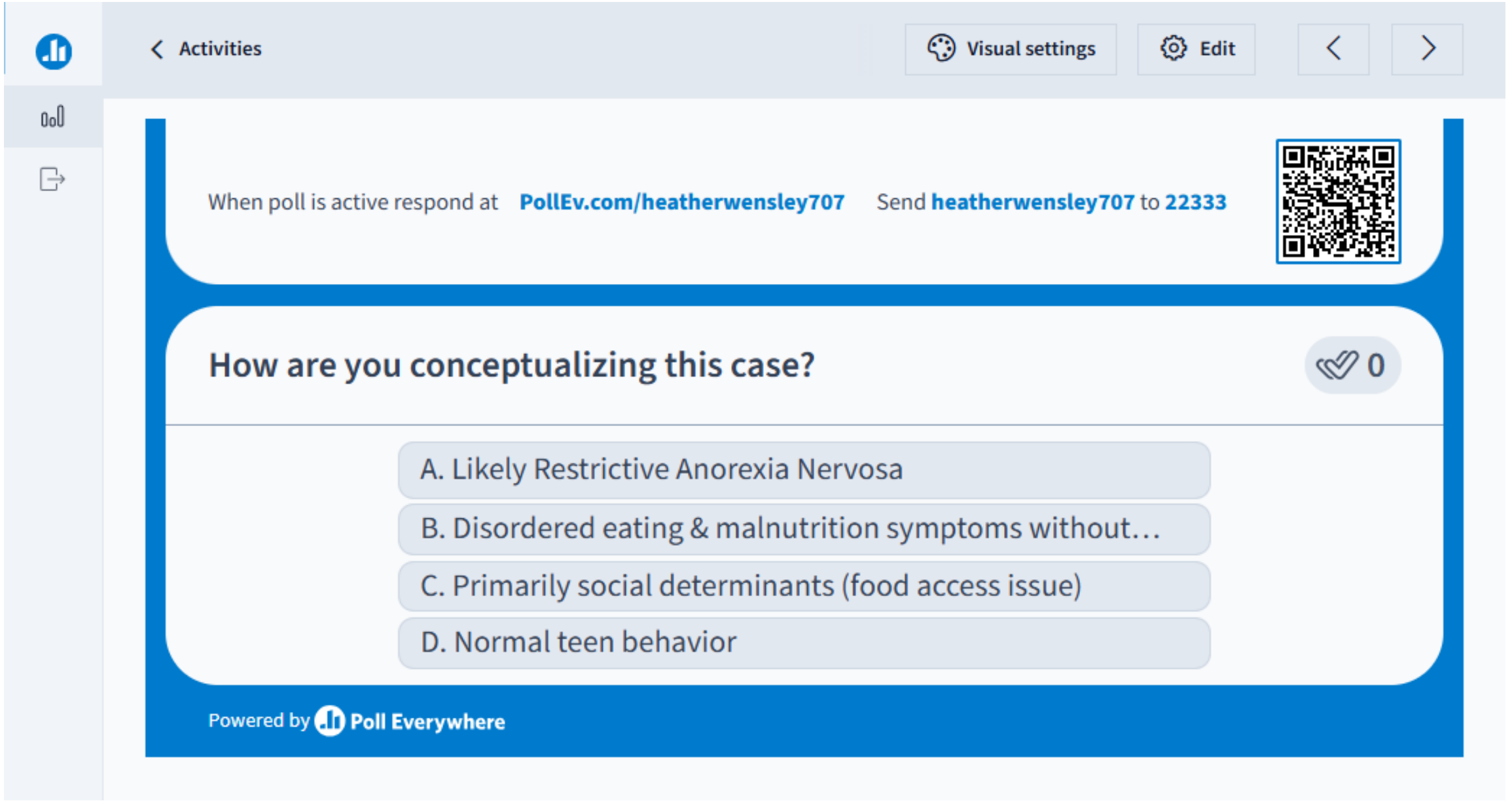
Also noticing some fatigue, trouble focusing in class, feeling cold

They are:

Open to talking and trying to eat more

Aware that symptoms (headache, dizziness, fatigue, poor focus) may be from not eating enough

They have access to: Free school breakfast/lunch, Snacks, Food pantry


Activities
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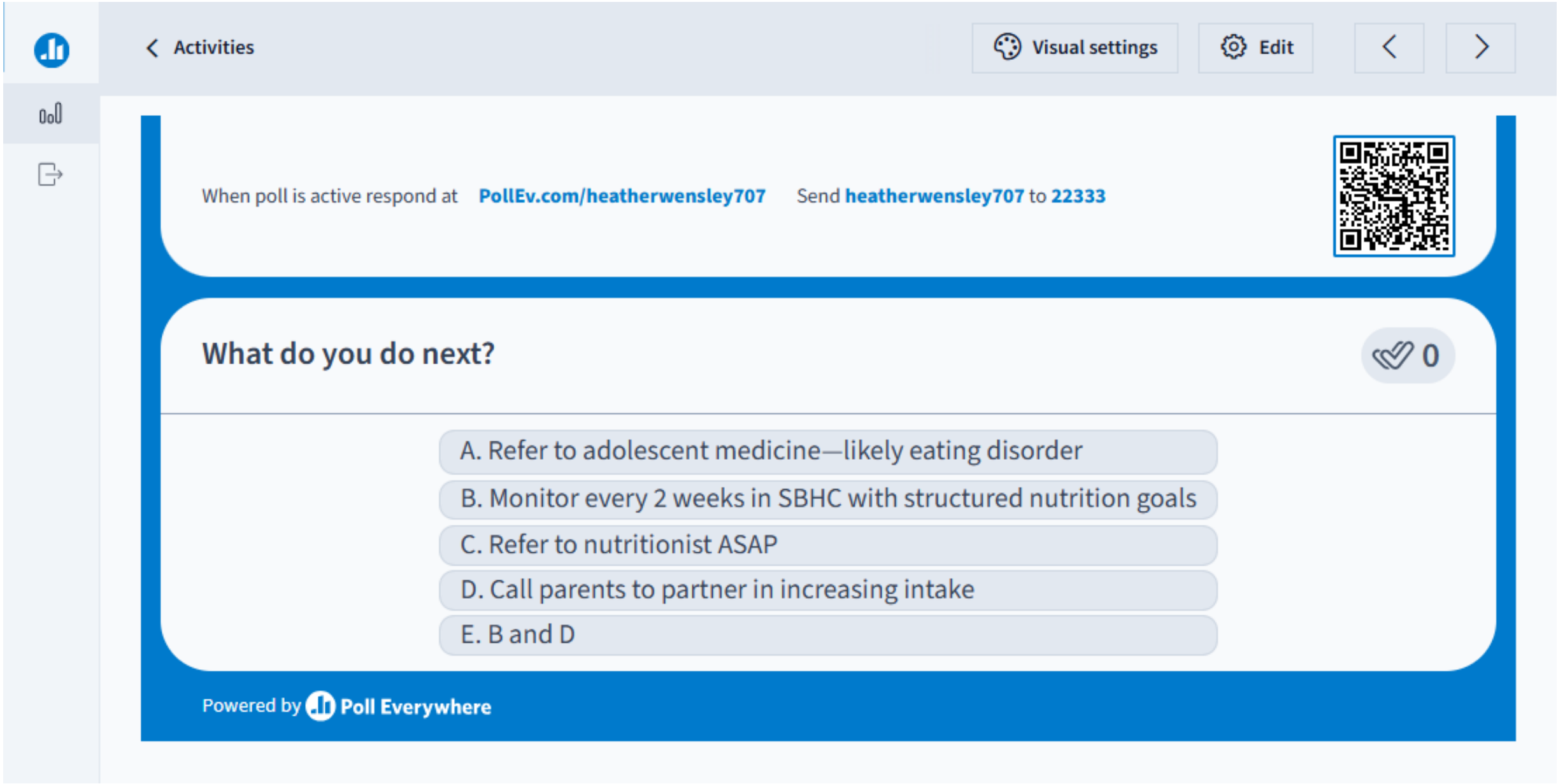
Edit
When poll is active respond at PollEv.com/heatherwensley707 Send heatherwensley707 to 22333
How are you conceptualizing this case?
0
A. Likely Restrictive Anorexia Nervosa
B. Disordered eating & malnutrition symptoms without…
C. Primarily social determinants (food access issue)
D. Normal teen behavior
Powered by Poll Everywhere


Activities
Visual settings
Edit
When poll is active respond at PollEv.com/heatherwensley707
Send heatherwensley707 to 22333
What do you do next?
0
A. Refer to adolescent medicine—likely eating disorder
B. Monitor every 2 weeks in SBHC with structured nutrition goals
C. Refer to nutritionist ASAP
D. Call parents to partner in increasing intake
E. B and D
Powered by Poll Everywhere

How to talk with this student about your recommendations and plan

Questions or Comments?

SCHOOL OF
NURSING
UNIVERSITY of ROCHESTER

Contact Information: Heather_Wensley@URMC.Rochester.Edu or
Megan_Sanna@URMC.Rochester.EDU

Works cited

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