Jackson Care Connect 2026 Virtual Learning Series

Advancing Health Equity, Access & Quality Care

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A dynamic, free virtual learning series designed to empower professionals in physical and behavioral health and community-based organizations. Enhance your skills and **earn Continuing Education Units (CEUs) and Continuing Medical Education credits (CMEs)** in support of providing members with high-quality, compassionate, informed care

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JCC Learning Series Core Values

- **Valuable sessions** on timely topics for professionals in physical and behavioral health, health equity, and community engagement.
- **Practical tools and strategies** to improve access, outcomes, and culturally connected care.
- **Cultivating network connections** to build collaboration across systems of care

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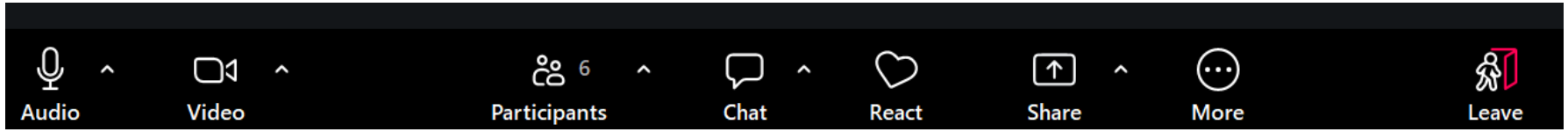
Joining us via Zoom today!

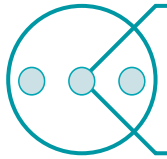
Using the toolbar



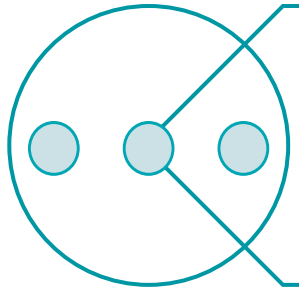
Please mute yourself, during the session

You can pop questions for the presenters into the chat.

You can visually signal a question by using the reactions and “raise your hand”



Hover over your own image and use the three dots on the top right to change how you are viewing the screen.



Use the three dots to access captions and the session transcript.

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CEUs Requirements

- ✓Participate in the entire length of the session.
- ✓By doing so, your name will be included in a session roster that will be submitted to NASW.
- ✓Complete the required evaluation within 10 days of the session. You will receive this via email.

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American Academy of Family Physicians (AAFP) CME

The AAFP has reviewed Understanding Whole Health Care for Eating Disorders and deemed it acceptable for up to 2.00 Live AAFP Prescribed credit(s).

Term of Approval is from 06/17/2026 to 06/17/2026. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Whole Health Care for Eating Disorders

Grace Laman, RD, LD, CSO
Suki Conrad, MD CEDS-S

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THE ROLE OF DIETITIANS IN THE TREATMENT OF EATING DISORDERS: MORE THAN JUST A MEAL PLAN

Grace Laman, RD, LD, CSO

Clinical Dietitian

June 17, 2026

EVOLVING ROLE OF DIETITIANS IN EATING DISORDER TREATMENT

PRIMARY FOCUS: Nutritional Status/Weight Restoration

SECONDARY GOALS:

Dependent on condition (Anorexia Nervosa vs Binge Eating vs ARFID)

- Expansion of Diet
- Creating Flexibility
- Intuitive Eating/Mindful Eating

Hart, S. et al., *Journal of Eating Disorders*, 2021.

Ward, A., *Nutrition & Dietetics in Eating Disorders*, 2020.

Academy of Nutrition & Dietetics: Evidence-Based Practice Guidelines 2022

- Dietary Assessment
- Heart Rate/Orthostatic Vitals
- Evaluation of Physical Symptoms
- Anthropometric Measurements
- Biochemical Assessment

EVALUATING NUTRITION STATUS

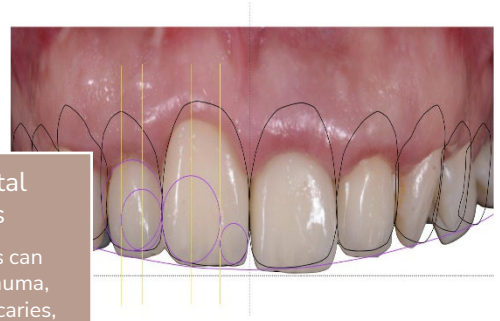
ORTHOSTATIC VITALS PROTOCOL

- **1.** Start with lying for 5 minutes and then check blood pressure and heart rate.
- **2.** Next stand for 3 minutes and then repeat blood pressure and heart rate.
- **Note: Do not have the patient sit between lying and standing as this negates the findings.**
- Patient is orthostatic hypotensive if there is a >10 point decrease in systolic and/ or a 20 point increase in heart rate.
- Increase of heart rate by 35 points or a 20 point drop in systolic blood pressure meets hospitalization criteria. A heart rate <50 beats per minute daytime also meet criteria for admission.

WHY APPEARANCE IS AN UNRELIABLE INDICATOR OF HEALTH

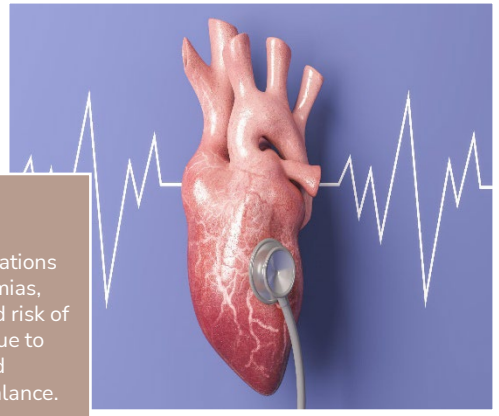
- Appearance Misleads Health Assessment
  - Health and illness cannot be accurately judged by body size, shape, or weight alone due to eating disorders' hidden nature.
- Consequences of Weight Bias
  - Weight bias causes underdiagnosis and delayed treatment, as symptoms are often mistaken for body size effects rather than illness.
- Holistic Health Factors
  - True health depends on nutrition, mental wellbeing, sleep, stress, and social support, not just weight or appearance.
- Ethical Clinical Practices
  - Clinicians should focus on behaviors and symptoms with open questions rather than assumptions based on appearance to reduce stigma.

ORAL, CARDIAC, AND GASTROINTESTINAL COMPLICATIONS



Oral and Dental Complications

- Eating disorders can cause mouth trauma, dental erosion, caries, and parotid gland swelling, often leading to distress.



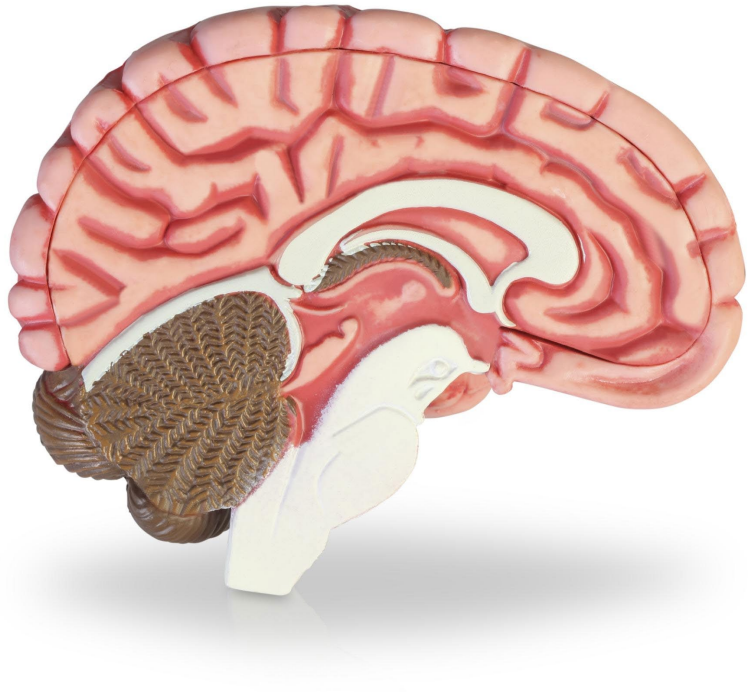
Cardiac Risks

- Cardiac complications include arrhythmias, bradycardia, and risk of sudden death due to malnutrition and electrolyte imbalance.

Gastrointestinal Symptoms

- Gastrointestinal issues like reflux, constipation, and gastric discomfort are common and can worsen eating disorder symptoms.

ENDOCRINE, NEUROPSYCHIATRIC, AND DERMATOLOGIC EFFECTS



- Endocrine Disruptions
  - Eating disorders cause hormonal imbalances like amenorrhea, infertility, and low bone density, raising fracture risks in youth.
- Neuropsychiatric Complications
  - Cognitive and emotional symptoms include memory loss, anxiety, depression, and high rates of self-harm and suicidal ideation.
- Dermatologic Signs
  - Skin and hair changes like lanugo, brittle nails, and calluses indicate chronic undernutrition and compensatory behaviors.

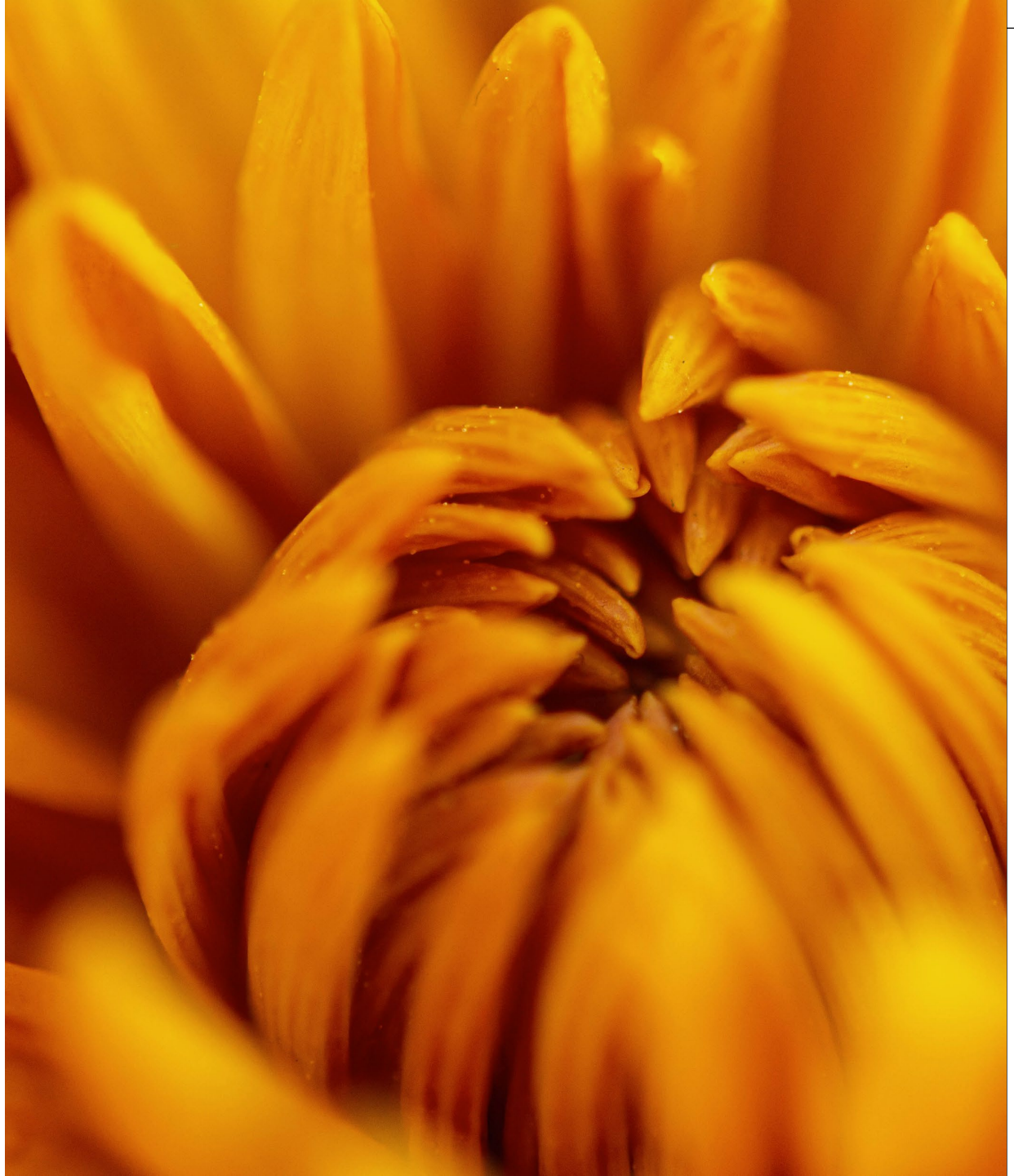
CLINICAL INTERVENTIONS PROVIDED BY DIETITIAN

- Individualized Meal Planning to support weight restoration/correction of nutrient deficiencies.
- Behavioral Strategies (in coordination with therapist): FBT Model of feeding
- Education: roles of macronutrients/effects of underfeeding/overfeeding

FAMILY BEHAVIORAL THERAPY WITH DIETITIAN

- Roles and Responsibilities in Feeding.
- Mealtime Scripts
- Fostering Eating Autonomy

Family-Empowered Treatment in Higher Levels of Care for Adolescent Eating Disorders: The Role of the Registered Dietitian Nutritionist - Journal of the Academy of Nutrition and Dietetics



CASE STUDY

PATIENT INFORMATION

Initials: D.S.

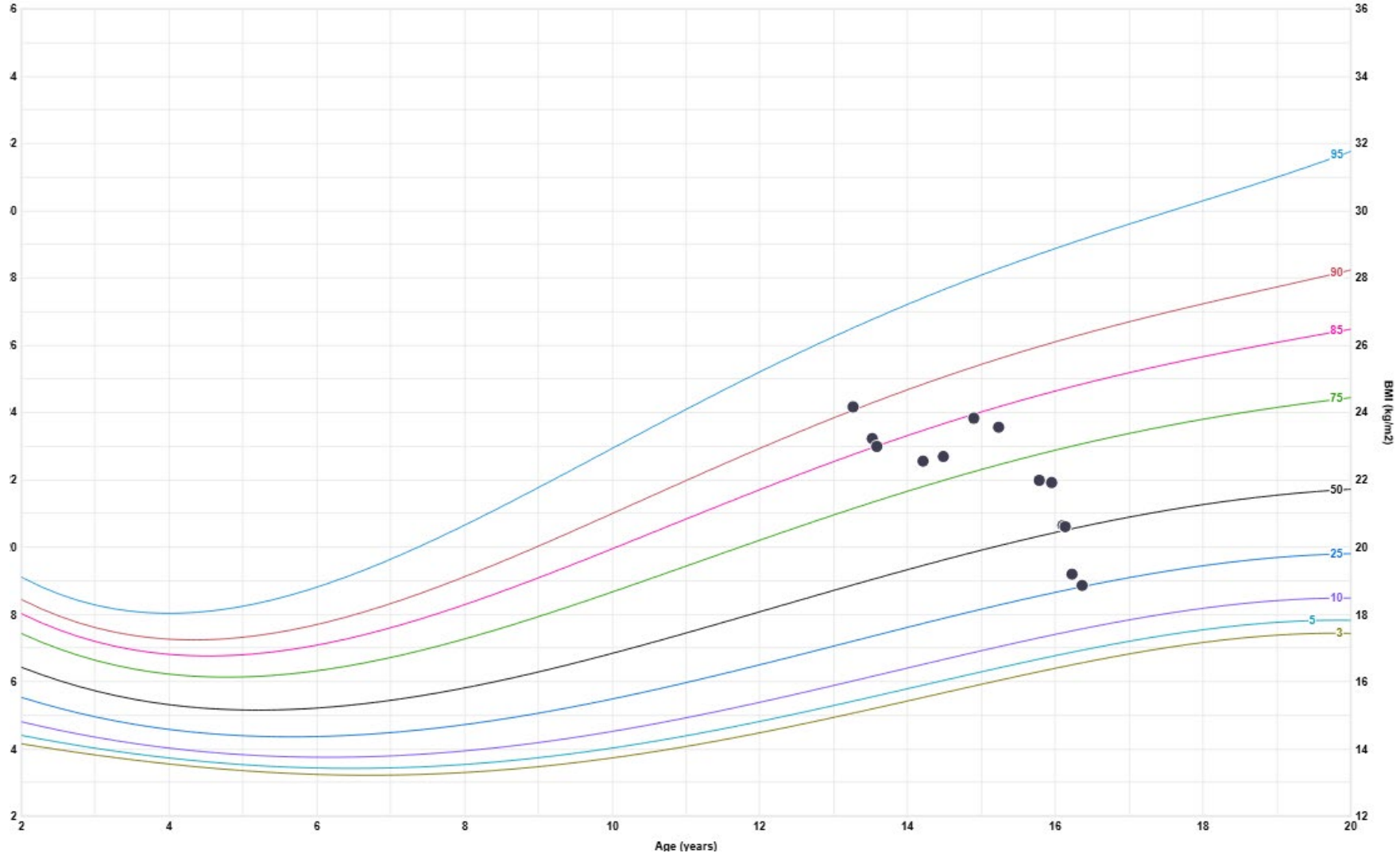
Age: 16 years, 8 months

Gender: Female

Hx of GAD, no other medical hx.

Presents to PCP for annual check up. PCP notes elevated BMI; checks labs and finds elevated cholesterol. Suggests to work on healthy eating and increasing activity, Follow up in 1 year.

GROWTH CHART



Physical: Signs of mild fatigue and hair thinning; stable vital signs; no bradycardia.
7/16/2024: Ht: 61”, Wt: 126 lbs, BMI%ile: 84%
9/3/2025: Ht: 61”, Wt: 109 lbs, BMI%ile: 52%

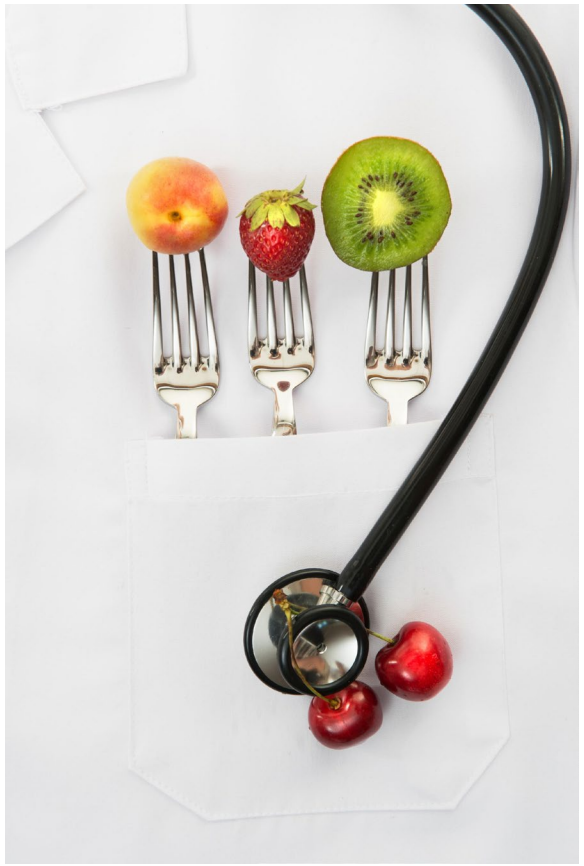
Laboratory tests: Mild anemia (Hb: 11.5 g/dL), low ferritin, cholesterol remains elevated.

Psychological: Anxiety (GAD7 score: 14/21), mild depressive symptoms (PHQ-9 score: 9/27).

Eating behavior: Highly controlled meals, exclusion of perceived “fattening” foods, now exercising 1-2 hours a day.

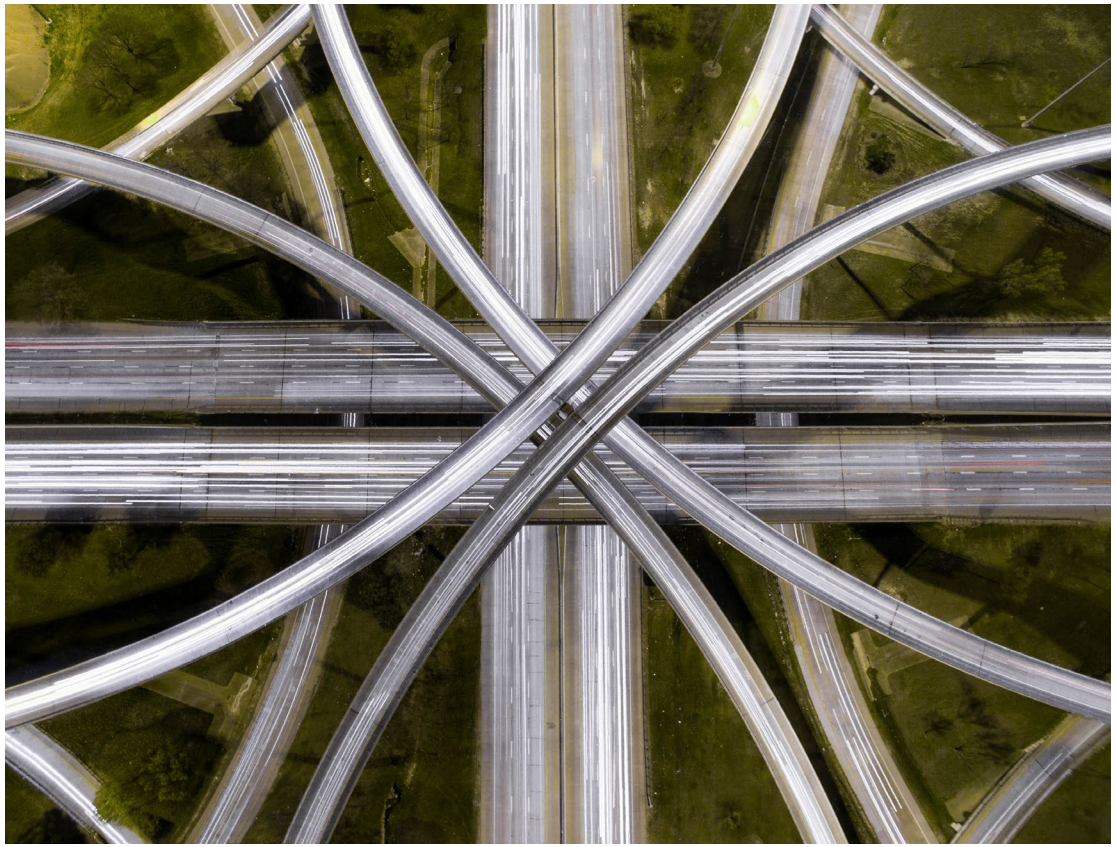
FOLLOW UP ASSESSMENT (COMPLETED BY PROVIDER)

DIETITIAN INTERVENTION



- Referral from PCP
  - Structured meal plan with specific components individualized to patient preferences initiated.
  - Meet with parent and teen separately and together.
  - FBT model initiated.
- Referral to therapist/support groups.
  - Use of Psychology Today website or school counselors to help with identifying therapist options.
  - Discuss free support groups (Center for Discovery, ANAD findhelp.org; FEAST-ED.org)
- Coordination with PCP for vitals checks.
- Establish on Recovery Record.

COLLABORATIVE CARE IMPROVES OUTCOMES



- Historical Exclusion of Dietitians
- Comprehensive Care
- Integrate nutritional assessment and intervention immediately.

QUESTIONS?

WHOLE HEALTH CARE FOR EATING DISORDERS

Marginalized Populations, Cultural Considerations, and Effective Collaboration

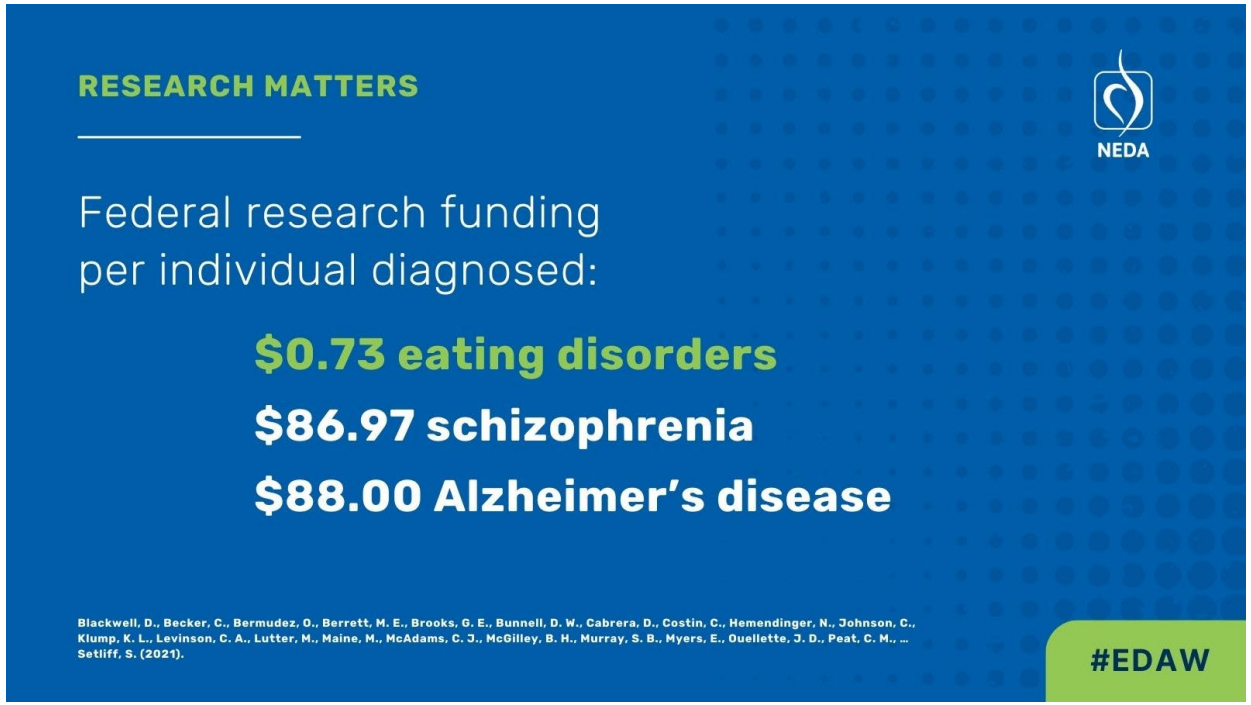
Suki Conrad, MD, CEDS-C

CareOregon Behavioral Health Medical Director

OBJECTIVES

1. Identify marginalized populations and recognize unique risk factors in terms of screening and diagnosis of eating disorders.
2. Increase awareness of cultural and intersectional considerations when evaluating for potential eating disorders.
3. Develop understanding of interdisciplinary approach to treatment and recognition of biases.

CURRENT EVIDENCE BASE



- Overall paucity of research funding specific to eating disorders
- Lowest funded mental health condition despite being second highest mortality rate
  - Only opioid use with higher mortality/morbidity

CURRENT EVIDENCE BASE

- Majority of research into eating has specifically been in white, cisgendered female, heterosexual, high socioeconomic status, Western/European-centric, treatment seeking, low body weight individuals.
- Individuals who volunteer to participate in research are *treatment-orientated* or *treatment seeking* which is a significant minority of the total population with eating disorders
  - 10-30% of individuals diagnosed with an eating disorder will seek treatment
  - 10-25% of individuals meeting clinical criteria will be assessed and diagnosed
  - Involuntary treatment for eating disorders is exceptionally rare outside of youth populations
- This has impacted how the diagnostic criteria has been developed, validation of scales/screening tools, and treatment efficacy.

SCREENING ASSESSMENTS

TABLE 2. Screening questionnaires for eating disorders

SCOFF Questionnaire (Morgan et al. 1999)

Do you make yourself **S**ick because you feel uncomfortably full?

Do you worry you have lost **C**ontrol over how much you eat?

Have you recently lost >14 lbs (**O**ne stone) in a 3-month period?

Do you believe yourself to be **F**at when others say you are too thin?

Would you say that **F**ood dominates your life?

Screen for Disordered Eating (Maguen et al. 2018)

Do you often feel the desire to eat when you are emotionally upset or stressed?

Do you often feel that you can't control what or how much you eat?

Do you sometimes make yourself throw up (vomit) to control your weight?

Are you often preoccupied with a desire to be thinner?

Do you believe yourself to be fat when others say you are too thin?

Eating Disorder Screen for Primary Care (Cotton et al. 2003)

Are you satisfied with your eating patterns? (A "no" to this question is classified as an abnormal response.)

Do you ever eat in secret? (A "yes" to this and all other questions is classified as an abnormal response.)

Does your weight affect the way you feel about yourself?

Have any members of your family suffered with an eating disorder?

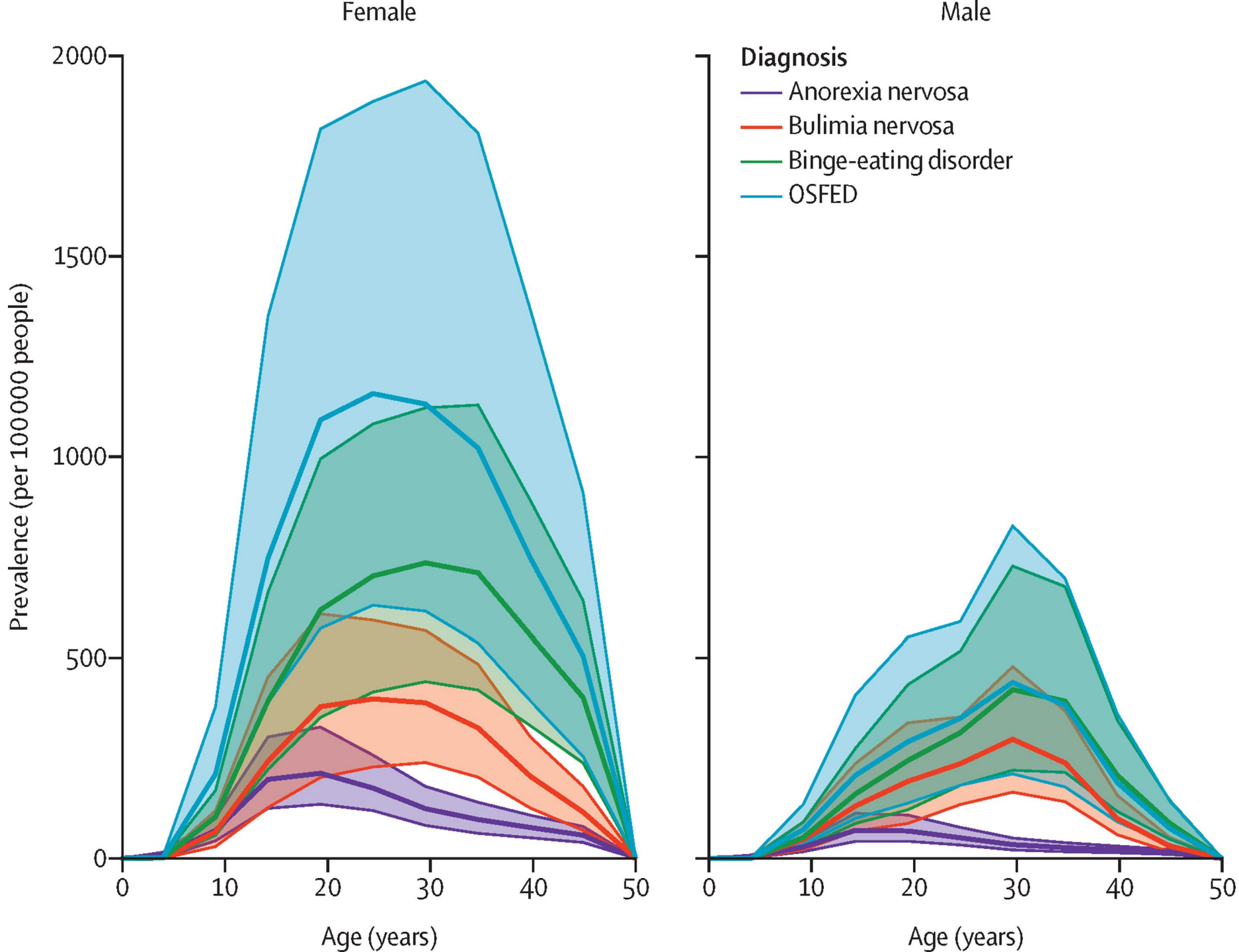
Do you currently suffer with or have you ever suffered in the past with an eating disorder?

DSM 5 DIAGNOSES

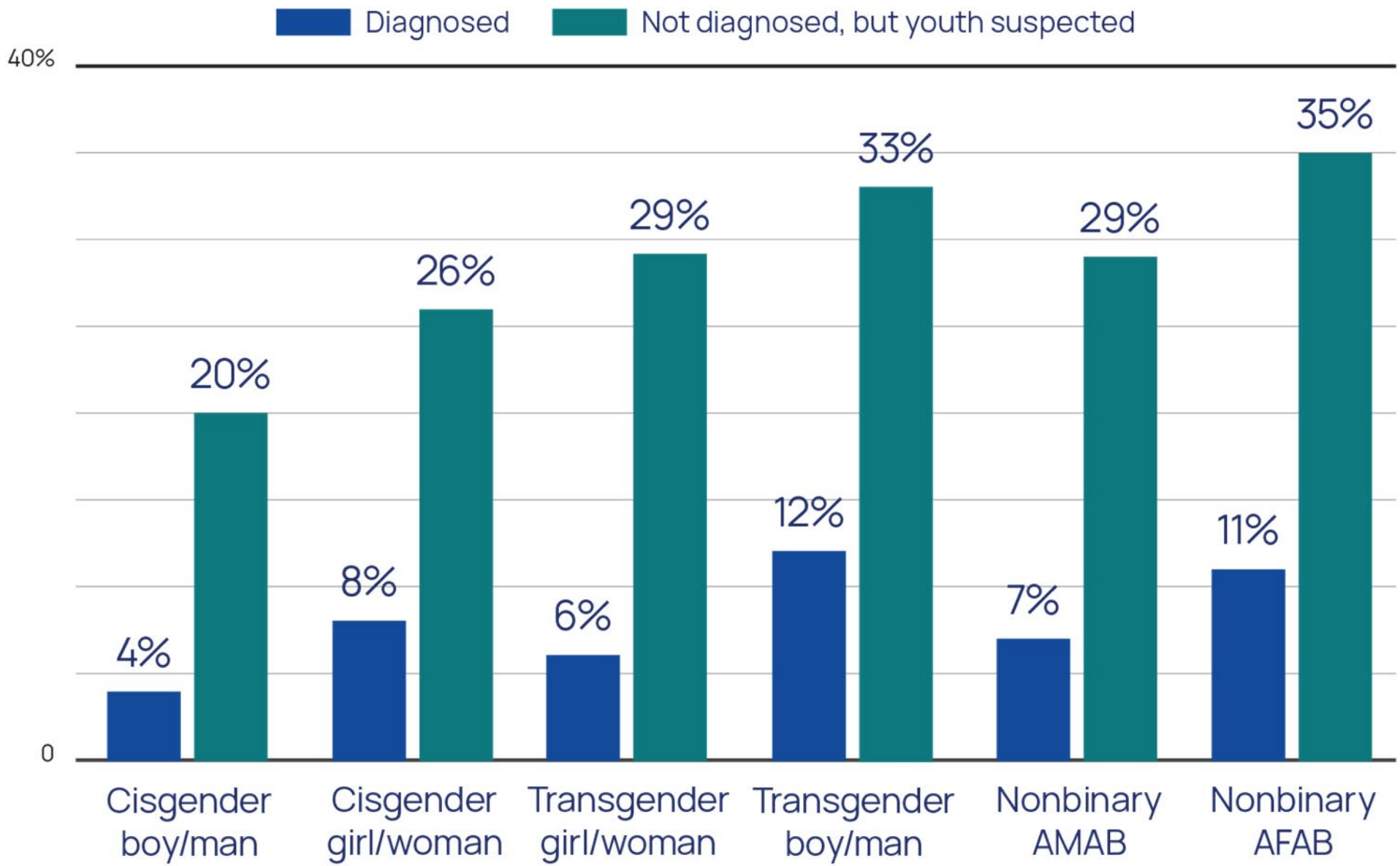
F98.3 (children) and F50.8 (adults) Pica	F98.21 Rumination Disorder	F50.8 Avoidant/Restrictive Food Intake Disorder	F50.01x Anorexia Nervosa, restricting type F50.02x Anorexia Nervosa, binge-eating/purging type
F50.2x Bulimia Nervosa	F50.8x Binge-Eating Disorder	F50.8 Other Specified Feeding or Eating Disorder	F50.9 Unspecified Feeding or Eating Disorder

UNDER-IDENTIFIED (AND UNDERTREATED) GROUPS

- Higher weight/larger body sized
- All ethnicities/racial groups other than White
- Socioeconomically disadvantaged
- Males
- Gender minorities
- Sexual minorities
- Individuals with neurodevelopmental disorder(s)
- Older individuals


Female
Male
Diagnosis
Anorexia nervosa
Bulimia nervosa
Binge-eating disorder
OSFED
Prevalence (per 100 000 people)
2000
1500
1000
500
0
0
10
20
30
40
50
Age (years)
Age (years)

Percentage of LGBTQ Youth Who Reported an Eating Disorder by Gender Identity



SOCIOECONOMIC STATUS AND INTERSECTIONALITY

- Lower SES 1.27 times greater prevalence of positive ED screen than higher SES after adjusting for age, gender identity, sexual orientation, and race/ethnicity
- 52% of bisexual men and 52% of lesbian women of Latinx ethnicity and lower SES screened positive

Table 3.

Statistically significant differences in age-adjusted prevalence estimates of positive SCOFF based on intersectional ("observed") versus additive ("expected") models

	Difference in Observed Versus Expected Age-Adjusted Prevalence Estimate
Observed prevalence statistically significantly greater than expected based on each individual social identity	
Hispanic/Latino bisexual men of lower SES	27.2% greater than expected
Asian/Asian American bisexual men of higher SES	12.9% greater than expected
Hispanic/Latino gay men of lower SES	10.7% greater than expected
White gay men of lower SES	10.3% greater than expected
White gay men of higher SES	9.5% greater than expected
White heterosexual women of higher SES	1.3% greater than expected
Observed prevalence statistically significantly lower than expected based on each individual social identity	
Hispanic/Latina lesbian women of higher SES	29.2% lower than expected
Asian/Asian American lesbian women of lower SES	24.4% lower than expected
Black/African American lesbian women of higher SES	20.2% lower than expected
Hispanic/Latina bisexual women of higher SES	11.3% lower than expected
White lesbian women of lower SES	10.2% lower than expected
Asian/Asian American bisexual women of lower SES	9.6% lower than expected
White lesbian women of higher SES	8.3% lower than expected
White heterosexual men of higher SES	2.5% lower than expected

Note. SES = socioeconomic status. Within each section of the table, differences in observed versus expected age-adjusted prevalence estimates are listed in descending order by the magnitude of difference.

UNIQUE RISK FACTORS IN MARGINALIZED RACIAL/ETHNIC GROUPS

- Note: These labels are imperfect and represent heterogenous population groups; however, they reflect how the data is presented in current research methodologies.

- Common themes
  - Stigma regarding mental health and mental health treatment
  - Acculturative stresses
  - Impacts of racism, discrimination in general, and specifically in health care settings

CULTURAL BODY SHAPE IDEALS AND EATING DISORDER SYMPTOMS AMONG WHITE, LATINA, AND BLACK COLLEGE WOMEN (2010)

- Black – discrepancy between perceived mainstream ideal and perceived body shape more frequently related to eating disorder symptoms
- Latinx – discrepancy between perceived ethnic group ideal and perceived body shape more frequently related to eating disorder symptoms
- Greater levels of acculturative stress predicted higher levels of drive for thinness (Latinx) and bulimic symptoms (Black); did not significantly predict eating disorder symptoms

UNIQUE RISK FACTORS IN MARGINALIZED RACIAL/ETHNIC GROUPS

- Asian
  - Prevalence equal to or higher than White
  - Gender-based body idealization, cultural focus on self-control/discipline
    - Men may be at particular risk for shame due to gender-based norms regarding masculinity
  - Emphasis on social acceptance/avoidance of criticism from others
  - Failure of the individual may generalize to be a failure of the family system
  - May present with more somatic complaints and fear of weight gain rather than identify body shape/size dissatisfaction
  - Fasting may be more socially accepted, both culturally and religious practice

UNIQUE RISK FACTORS IN MARGINALIZED RACIAL/ETHNIC GROUPS

- Black
  - Similar incidence of bulimia nervosa and binge eating disorder
    - Black women are typically rated as having fewer eating disorder symptoms then compared to White women
  - May be more at risk of weight related bias from health care providers
  - Body dissatisfaction may be experienced in ways that are not due to weight or perceived thinness
  - Experience of and vicarious exposure to racial discrimination are both predictive of ED pathology in Black women

UNIQUE RISK FACTORS IN MARGINALIZED RACIAL/ETHNIC GROUPS

- Indigenous
  - Incredibly limited data available
  - American Indians, Alaskan Natives, and Native Hawaiian experience ED symptoms at rates similar and higher than White
  - Research in indigenous peoples of Australia, Aotearoa New Zealand, and Canada show higher rates of ED than other ethnic groups in those countries
  - Colonization, cultural suppression, and intergenerational trauma
  - Disruption of traditional food practices

UNIQUE RISK FACTORS IN MARGINALIZED RACIAL/ETHNIC GROUPS

- Latinx
  - Binge eating behaviors may present before restriction or compensatory behaviors, unlike in White and Black populations
  - Cultural importance of food and meals
  - Gender related expectations around women which change based on stage of life
  - Western perception of “health” of traditional foods/diet

INDIVIDUALS OF HIGHER-BODY WEIGHT

- Diagnosis of Anorexia Nervosa :
  - Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. ***Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.**
  - Severity modifiers added 10/2025 based on BMI (adults) or z-scores (children)

- Diagnosis of Atypical Anorexia Nervosa includes all the same criteria except for the above requirement for “significantly low body weight.”

ATYPICAL ANOREXIA NERVOSA

- Prevalence of atypical anorexia nervosa by age 20 years is 2.8% vs < 1% for anorexia nervosa
- All measures in Atypical Anorexia Nervosa are equally or more severe than Anorexia Nervosa
  - Physiologic, hormonal, emotional/behavioral
- Less likely to have disordered eating behaviors identified than normal weight or under-weight individuals
- Less likely to receive inpatient medical care despite equal severity
- More likely to meet severe malnutrition criteria due to rapid weight loss and percentage of weight loss

BARRIERS TO TREATMENT

TABLE 5 Barriers to Treatment by individual characteristics and eating disorder presentation (%)

	Barrier 1	Barrier 2	Barrier 3
Overall ($N = 1,483$)	I prefer to deal with issues on my own (28.1)	I have not had a need for counseling or therapy (23.0)	I'm not sure how serious my needs are (19.7)
Sex			
Female	I prefer to deal with issues on my own (27.9)	I have not had a need for counseling or therapy (22.5)	I'm not sure how serious my needs are (22.4)
Male	I prefer to deal with issues on my own (28.6)	I have not had a need for counseling or therapy (24.7)	I'm not sure how serious my needs are (12.1)
Race/ethnicity			
White	I prefer to deal with issues on my own (28.7)	I have not had a need for counseling or therapy (25.3)	I'm not sure how serious my needs are (20.4)
Student of color	I prefer to deal with issues on my own (25.8)	I'm not sure how serious my needs are (18.1)	I have not had a need for counseling or therapy (15.2)
Socioeconomic background			
Affluent	I prefer to deal with issues on my own (28.3)	I have not had a need for counseling or therapy (24.4)	I'm not sure how serious my needs are (19.1)
Non-affluent	I prefer to deal with issues on my own (28.0)	I have not had a need for counseling or therapy (22.7)	I'm not sure how serious my needs are (20.1)
Weight			
UW	There are financial reasons (14.2)	I worry that someone will notify my parents (14.2)	Issues related to eating and body image are normal in college (14.2)
HW	I prefer to deal with issues on my own (31.4)	I have not had a need for counseling or therapy (26.4)	I'm not sure how serious my needs are (20.9)
OW	I prefer to deal with issues on my own (29.7)	I have not had a need for counseling or therapy (24.0)	I'm not sure how serious my needs are (23.2)
OB	I prefer to deal with issues on my own (19.1)	I don't have time (16.1)	I'm not sure how serious my needs are (15.3)
Eating disorder symptom presentation			
Threshold AN	–	–	–
Threshold BN	I prefer to deal with issues on my own (26.7)	I have not had a need for counseling or therapy (17.9)	I'm not sure how serious my needs are (17.5)
Threshold BED	I prefer to deal with issues on my own (29.8)	I'm not sure how serious my needs are (25.4)	I don't have time (19.5)
Sub-threshold BN	I prefer to deal with issues on my own (25.0)	I have not had a need for counseling or therapy (23.5)	I'm not sure how serious my needs are (20.2)
Sub-threshold BED	I prefer to deal with issues on my own (41.4)	I have not had a need for counseling or therapy (40.3)	I'm not sure how serious my needs are (28.4)
PD	I have not had a need for counseling or therapy (29.3)	I prefer to deal with issues on my own (24.4)	I'm not sure how serious my needs are (11.6)

Note. Table values are percentages of the weighted sample. For each individual characteristic and eating disorder symptom presentation, the three most commonly reported barriers to treatment are reported. Estimates for threshold AN could not be computed due to small size and survey weighting.

BARRIERS TO TREATMENT – BRAIN CHANGES

- A starved brain is a regressed, irritable, depressed, anxious, ruminative brain!
  - Minnesota Semi-Starvation Study and later follow up
- Malnutrition alters insula activity, leading to disturbed interoceptive awareness
  - Decreased hunger sensation
  - Distorted body image
  - Lack of recognition of malnutrition
  - Diminished motivation to change
  - Numbed emotions
  - Altered sense of self
- Altered reward processing

MULTIDISCIPLINARY TEAM

Core

- Primary care provider
- Therapist
- Dietitian

Ideal

- Psychiatric provider
- Family therapist
- Substance use treatment provider
- Meal support coach
- Peer/family support

INITIAL EVALUATION OF EATING DISORDER

- Height and weight history over the lifespan (for medical and dietary providers)
  - For children/adolescents/young adults, growth charts
- Specific behaviors around consumption of food
  - Restrictive eating, specific diets, food avoidance, binge episodes, rumination, regurgitation, chewing and spitting, excessive use of condiments, water loading, intermittent fasting or specific timed eating, etc.
- Specific behaviors around food variety
  - Change in variety (increase or decrease), elimination of food groups (gluten, sugar, animal proteins, etc.)
- Compensatory behaviors
  - Exercise, purging behaviors (laxatives, vomiting, mis-use of insulin or other medications), other use of medication to manipulate weight
- Percentage of time preoccupied with food, weight, and body shape
- Family and/or individual history of prior treatment and response to treatment
- Family food rules/practices, cultural considerations
- Psychosocial impairments, mental health conditions/concerns, physical health conditions/concerns

TREATMENT: STABILIZE NUTRITION FIRST AND ALWAYS

- Nearly all eating disorders have some component of restriction, either as a primary or a compensatory behavior
- Weight restoration and weight gain
  - Weight restoration always involves weight gain
  - Talking about numbers may be helpful for some and hurtful for others
  - All movement burns calories
  - Children and adolescents are growing and are expected to increase in height and weight
  - Hypermetabolism may last 2+ years after weight restoration
- Be aware of language used
  - “Healthy/Unhealthy”
    - Consider words such as nutritious, nutrient dense/nutrient deficient, palatable
  - “Good/Bad”
    - What is a “good” food? Does food have a moral/ethical judgement attached?
    - Bad” foods are foods that are spoilt or you are allergic to

TREATMENT CONSIDERATIONS FOR PRIOR HIGHER WEIGHT

- Don’t be afraid of previous weight curves
- Larger bodies require more calories, not less
- Identify weight bias in family, patient, providers
- Empower individuals to discuss eating disorder with new providers, request blind weights
- For children/adolescents/young adults, remind individual and family that it’s expected for developing people to gain weight every year
- Don’t recommend future weight loss

CULTURAL CONSIDERATIONS

- Consider culturally relevant beliefs and practices
- Consider multidimensional conceptualizations around body image
- Consider familial/cultural perceptions of individual’s weight or shape
- Consider utilizing the medical model/externalizing the illness to destigmatize and reduce shame.

CULTURAL CONSIDERATIONS – ASIAN AMERICANS

- Assessing self-construal or individualist-collectivistic orientation (The Self-Construal Scale)
- Separate the individual from the illness
- Family based treatments may be more efficacious, but do need cultural adaptations
- For bulimia nervosa, Cognitive Behavioral Therapy has been found more effective in increasing abstinence from binging and purging

- https://www.asianmentalhealthproject.com/
- https://www.asianmhc.org/

CULTURAL CONSIDERATIONS – BLACK

- Consider racism and discrimination
- Consider food scarcity, food deserts, socioeconomic contributors
- Consider external stressors as primary drivers for behaviors

- https://anad.org/get-support/anad-approach-guides/black-community-mental-health-resources/

CULTURAL CONSIDERATIONS – LATINX

- Consider level of awareness/acceptance of mental health in family/community
- Role of family support and need for family involvement and education
- Complex gendered expectations

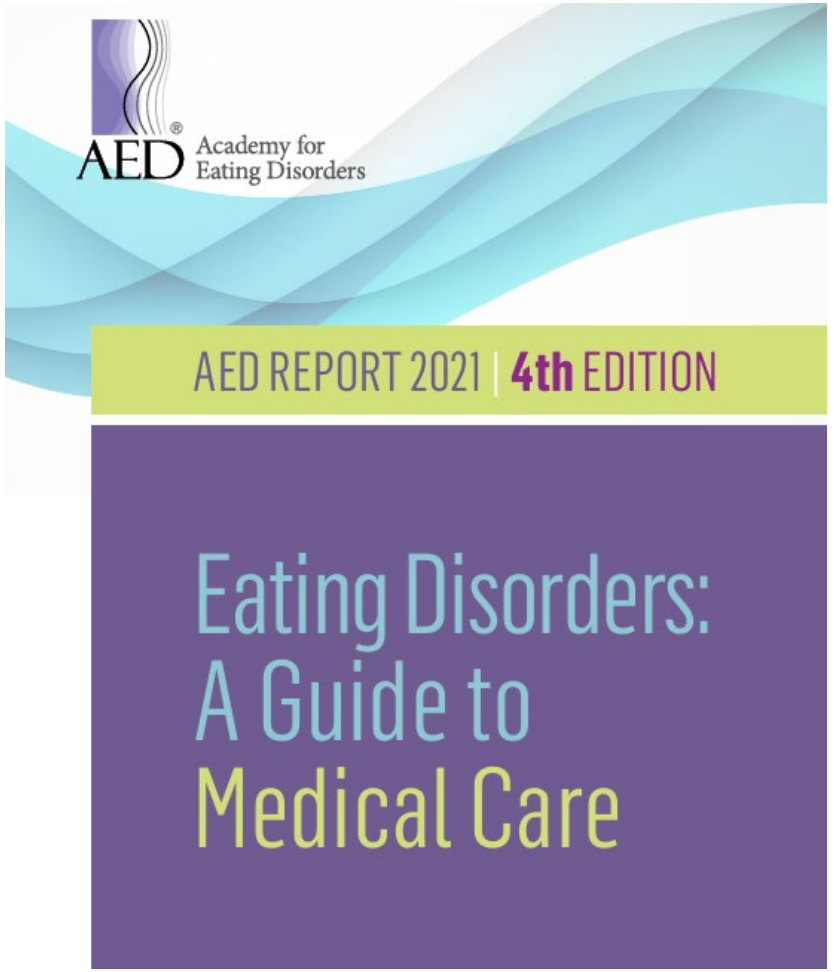
- https://nedic.ca/bipoc/latine-community-members/

HOW TO SUPPORT

- Communicate with other treating providers
  - Cannot understate the need for a team-based approach in treatment
- Recognize your own bias(es)
  - Weight, appearance, food, cultural, etc.
- Be aware of language use in session and documentation
- Weight stigma/bias is everywhere
- The people who need help the most are least likely to recognize need and least likely to present to care
  - Provide consistency; involve family, community; don’t align with the disorder

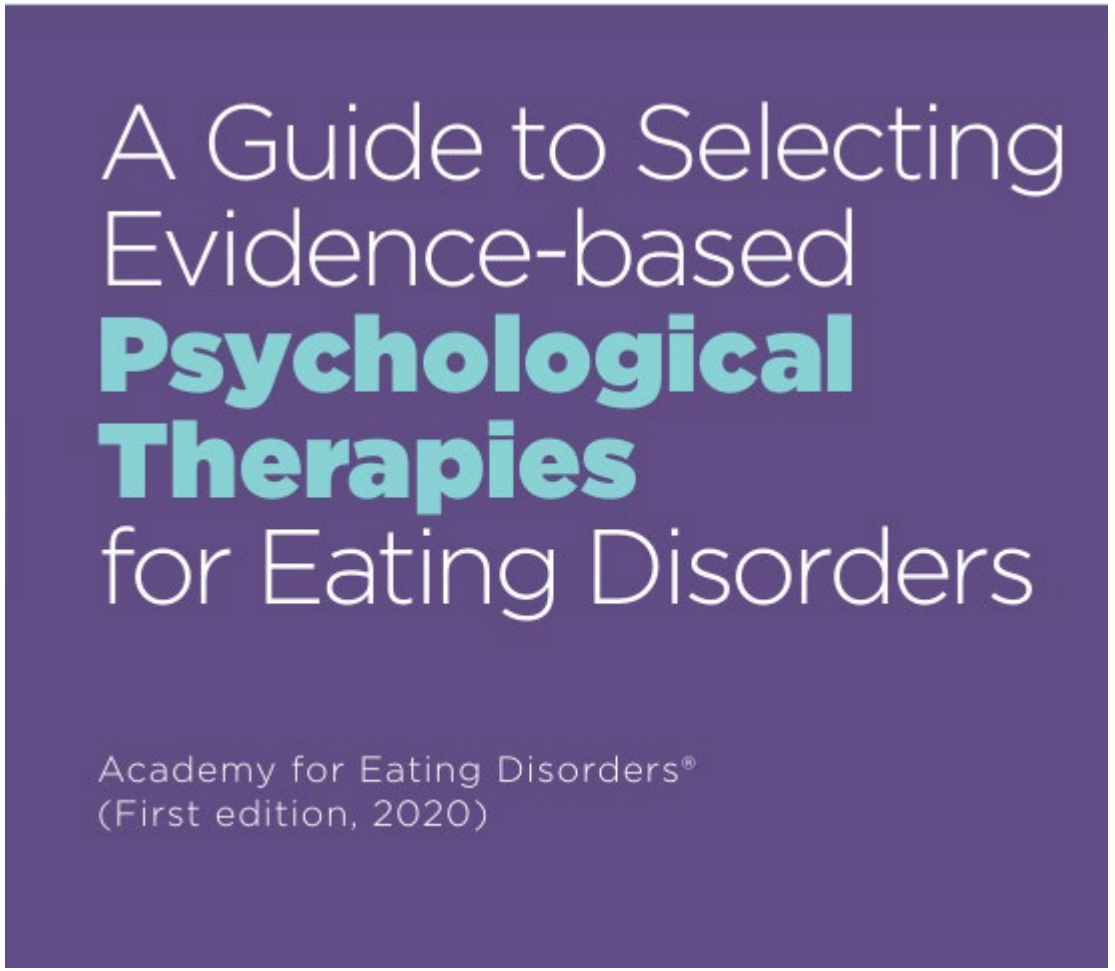
AED EATING DISORDERS: A GUIDE TO MEDICAL CARE, 4TH EDITION

https://higherlogicdownload.s3.amazonaws.com/AEDWEB/27a3b69a-8aae-45b2-a04c-2a078d02145d/UploadedImages/Publications_Slider/2120_AED_Medical_Care_4th_Ed_FINAL.pdf



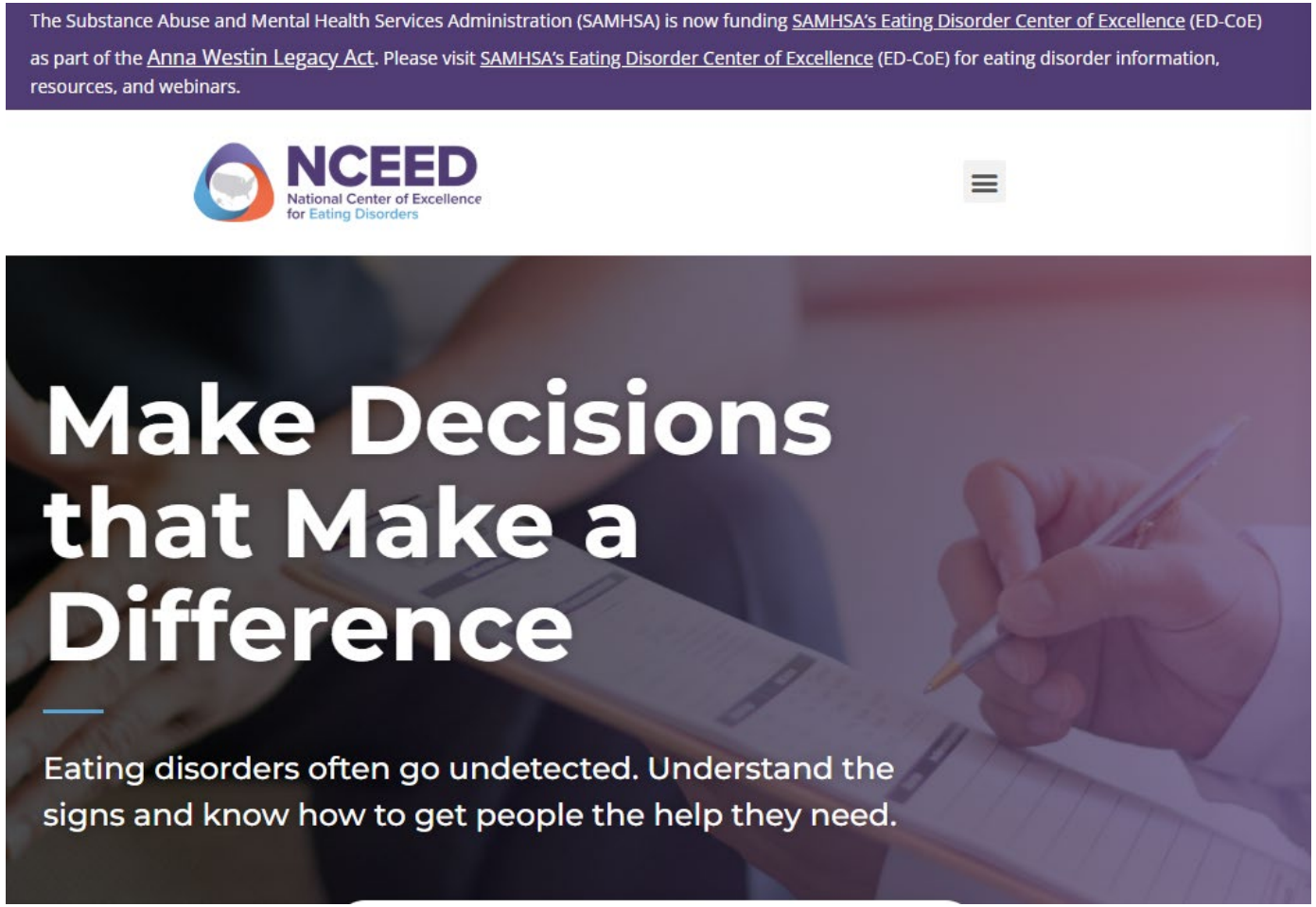
AED: A GUIDE TO SELECTING EVIDENCE-BASED PSYCHOLOGICAL THERAPIES FOR EATING DISORDERS

https://higherlogicdownload.s3.amazonaws.com/AEDWEB/27a3b69a-8aae-45b2-a04c-2a078d02145d/UploadedImages/Publications_Slider/FINAL_AED_Psycholohgical_book.pdf



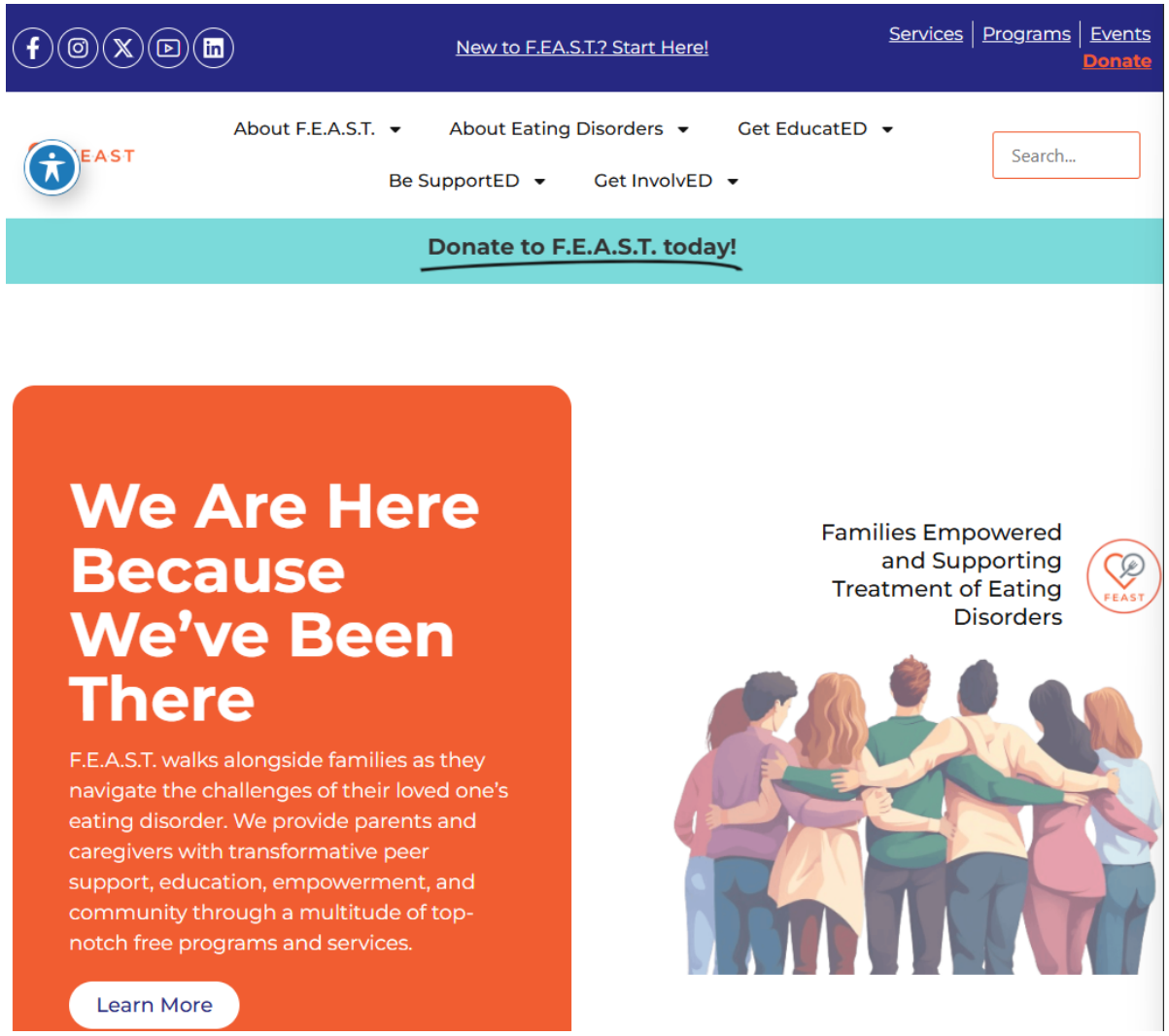
NATIONAL CENTER OF EXCELLENCE – EATING DISORDERS

https://nceedus.org/



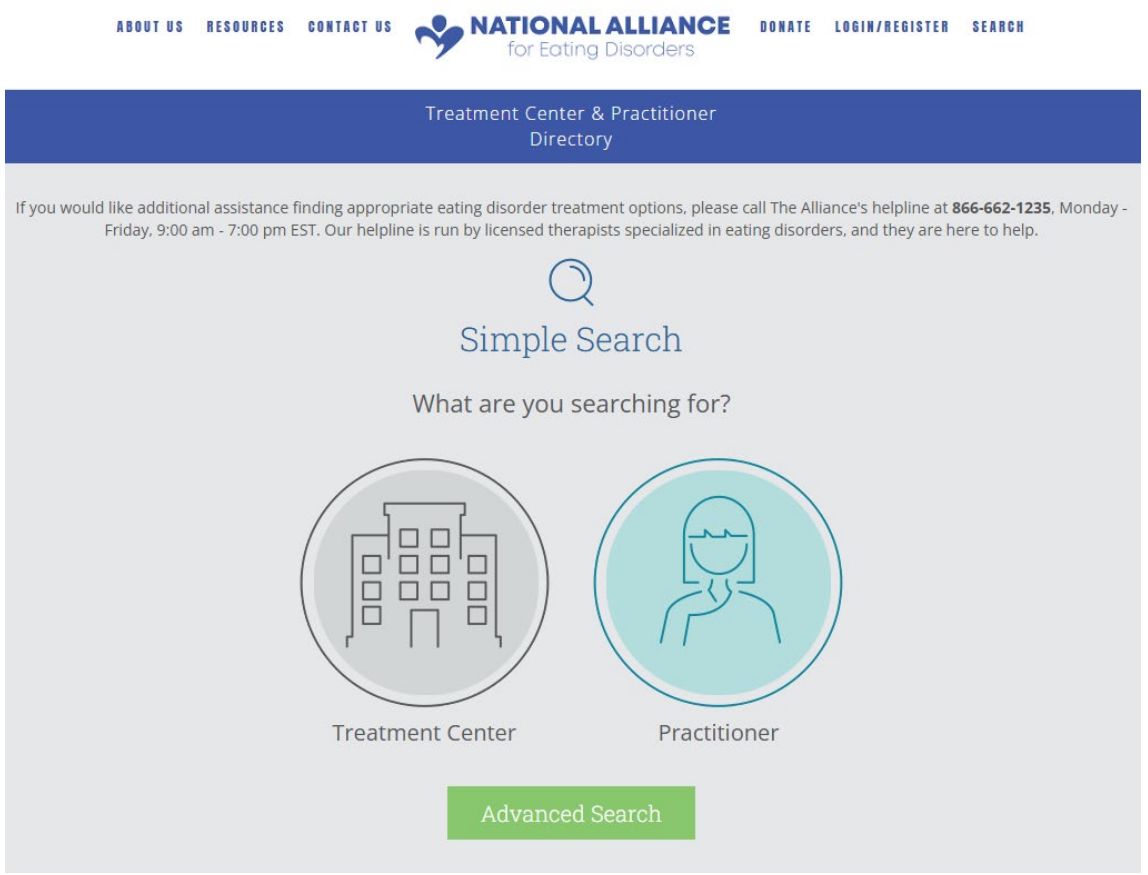
F.E.A.S.T.

https://feast-ed.org/



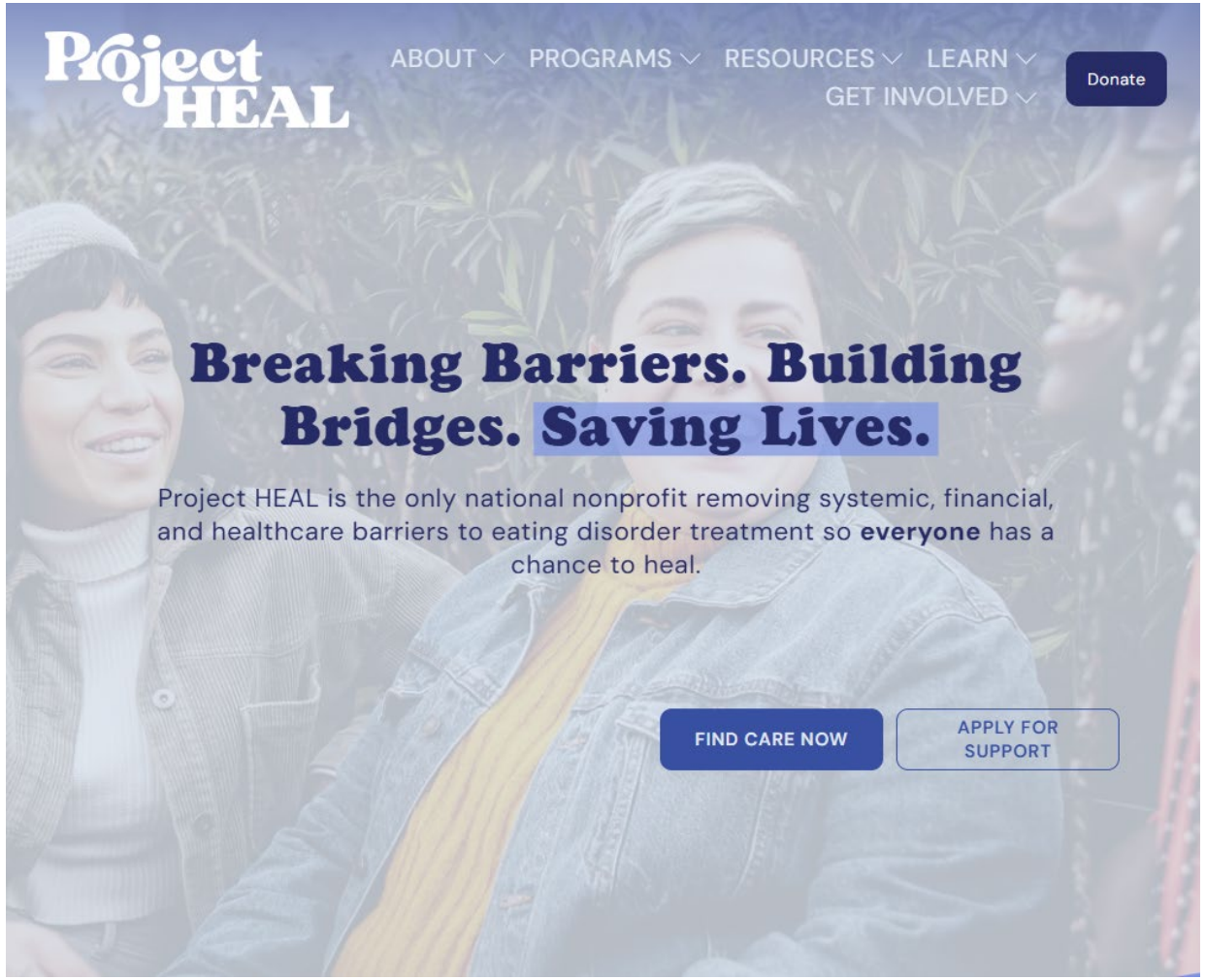
NATIONAL ALLIANCE FOR EATING DISORDERS

https://www.findedhelp.com/



PROJECT HEAL

https://www.theprojectheal.org/

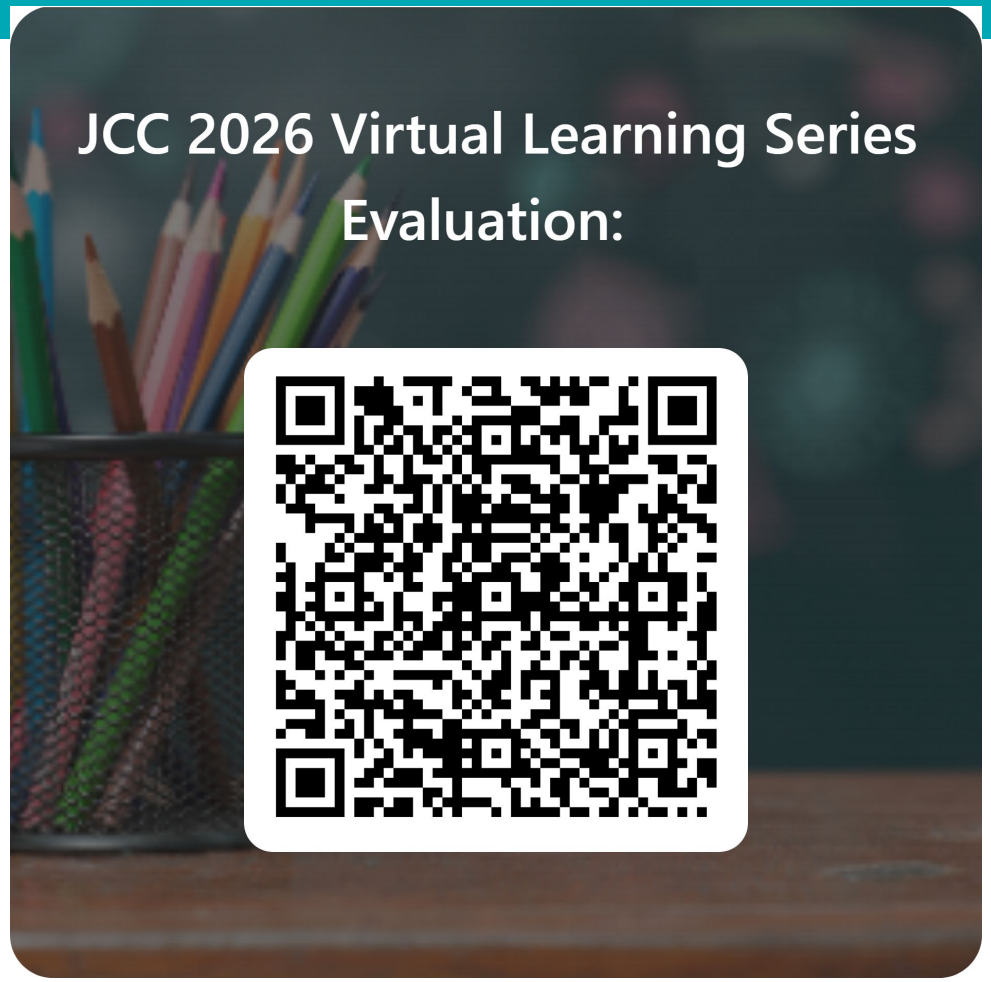


THANK YOU!

Evaluations

CEU credits require a completed evaluation.

Evaluations must be completed within 10 days.



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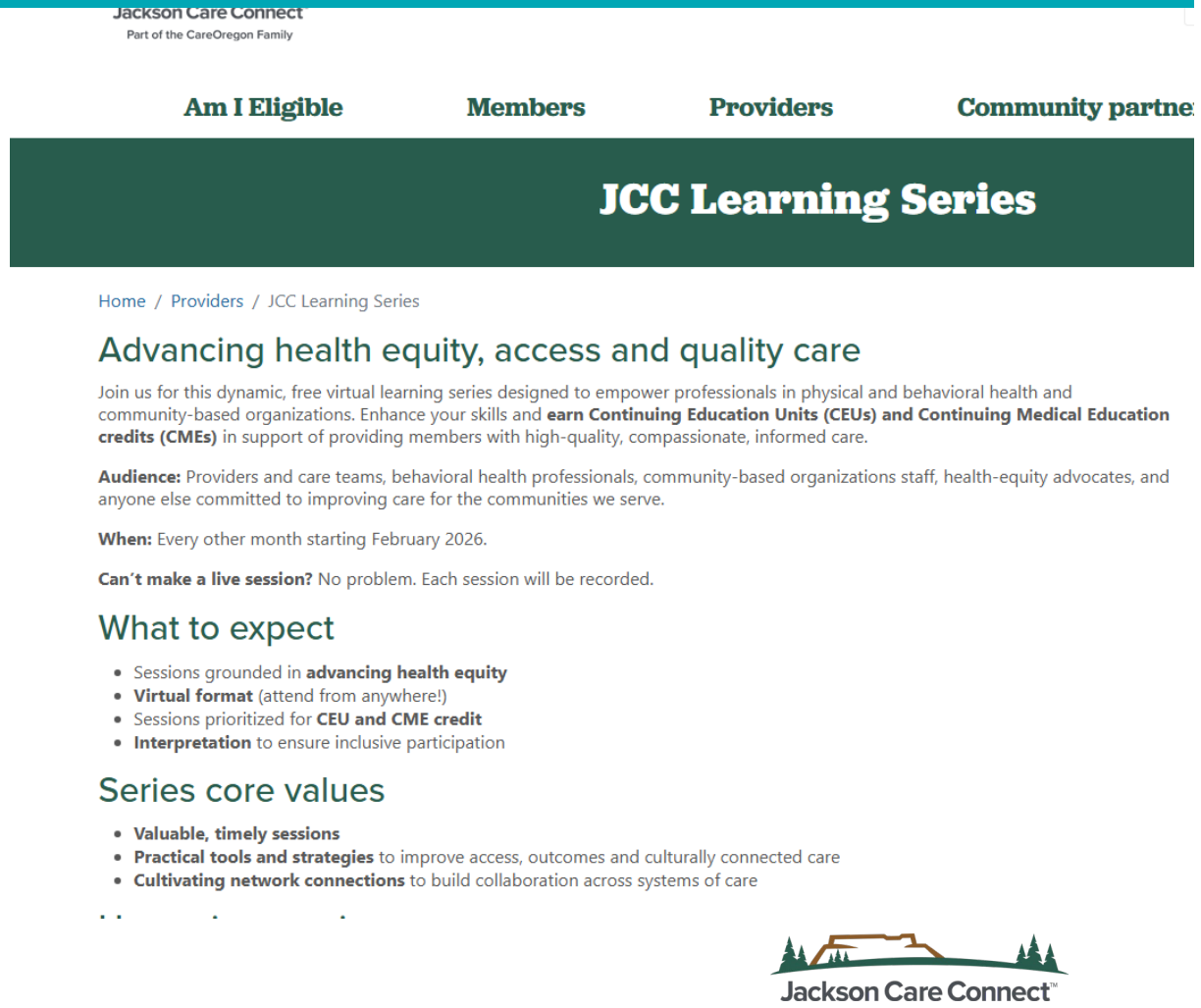
JCC 2026 Learning Series Resources

Interested in future sessions?

- Check the JCC Learning Series webpage for announcements and registration links

[JCC Learning Series]

https://jacksoncareconnect.org/providers/jcc-learning-series



Shared resources:

https://fedupcollective.org/

FEDUP Collective: Fighting Easting Disorders in Underrepresented Populations: A Trans+ & Intersex Collective

Jackson Care Connect™

Thank you!

If you have questions about the series, you can reach out to:

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Jackson Care Connect™
Part of the CareOregon Family