

FINAL REPORT

Geographic Accessibility of Eating Disorders Treatment Centers in the United States: A Nationwide Mapping Study

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A report prepared by the Strategic Training Initiative for the Prevention of Eating Disorders for the Consortium Representing Eating Disorders Care



Final Report to REDC

Geographic Accessibility of Eating Disorders Treatment Centers in the United States: A Nationwide Mapping Study

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Prepared by STRIPED for REDC

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Executive Summary

This project quantified and mapped geographic accessibility to eating disorder treatment (EDT) centers across the United States, distinguishing in-person and telehealth service modalities and summarizing variation by state and level of care. Using the National Alliance for Eating Disorders Find ED Help directory, we identified 387 EDT centers nationwide, including 220 offering in-person-only services, 108 offering both in-person and virtual services, and 59 offering virtual-only services.

Key findings show substantial state-to-state disparities in EDT availability and accessibility. In-person services are concentrated on the East and West Coasts and in selected Midwestern states, while many Central and Southern states have limited service availability. Several states/territories have no in-state in-person EDT services, constituting “EDT deserts” in within-state treatment scenarios.

Telehealth programs partially mitigate geographic gaps by providing cross-state coverage; however, telehealth availability remains uneven and is likely constrained by broadband subscription, affordability, and cross-state practice policies. Broadband subscription rates are lowest in several states with limited EDT resources, potentially compounding disparities.

1. Background and Rationale

Adequate geographic access to evidence-based eating disorder treatment is critical for recovery, yet the U.S. treatment system appears insufficiently distributed to meet population need. Prior formative work in Massachusetts demonstrated pronounced urban–rural and socioeconomic gradients in geographic accessibility, motivating a nationwide assessment to inform resource planning and policy.

2. Project Objectives

The primary objective was to systematically quantify and characterize the geographic dispersion of EDT centers in all U.S. states and territories and to evaluate disparities in geographic access to care. Specific aims included (1) assembling a comprehensive geocoded inventory of EDT centers; (2) distinguishing in-person and telehealth services and summarizing point-in-time treatment capacity by level of care; (3) generating accessibility indicators and state-level comparative maps; and (4) identifying states and regions with severe service gaps (EDT deserts) and potential structural barriers such as limited broadband availability.

3. Data Sources and Measures

3.1 EDT Center Inventory and Capacity Measures

We used the Find ED Help database provided by the National Alliance for Eating Disorders to extract center locations and program attributes, including service modality (in-person, telehealth, or both) and point-in-time treatment capacity indicators by level of care (e.g., partial hospitalization (PHP), intensive outpatient (IOP), residential (RES), and inpatient (IP) when available).

3.2 Broadband Context for Telehealth Access

To contextualize telehealth accessibility, we compiled subscription indicators from the U.S. Census Bureau's American Community Survey (ACS). This measure was defined as the proportion of households with an internet subscription, calculated as B28002_002E divided by B28002_001E (estimated households with an internet subscription / total households). These measures help assess whether telehealth services can feasibly reach populations in states with limited in-person treatment.

4. Methods

4.1 Service Modality Classification

Centers were classified into three mutually exclusive categories: in-person only, both in-person and telehealth, and telehealth only. For telehealth programs serving multiple states, telehealth capacity was apportioned across served states to avoid double-counting and to represent distributed availability.

4.2 Accessibility Metrics and Geospatial Workflow

We built a workflow-based geospatial analysis pipeline in KNIME to support computation of geographic accessibility scores, with mapping and visual analytics produced in ArcGIS. The planned primary accessibility metric is the two-step floating catchment area (2SFCA) approach, which quantifies accessibility as the ratio of supply capacity to population demand within defined travel-time or distance catchments.

4.3 Resolving Age-Group Definition Inconsistencies

Because age-range fields in the Find ED Help directory contain inconsistent definitions (e.g., Children, Adolescents/Teens, Adults), we implemented an automated web review workflow. Using Selenium-based web extraction to collect program webpages and a text analysis step to identify stated age ranges, we synthesized common definitions and adopted operational cut points (12 and 18 years) to harmonize age-group coding for subsequent analyses.

5. Results

5.1 National EDT Center Counts and Geographic Distribution

Across all U.S. states and territories, we identified 387 EDT centers. Of these, 220 offer in-person-only services, 108 offer both in-person and virtual services, and 59 offer virtual-only services. National maps show a pronounced coastal concentration of in-person services, with many Central and Southern states having fewer in-person resources. This geographic clustering implies that, under realistic travel constraints, patients in large parts of the country may face substantially longer travel times or may need to rely on out-of-state options. **Figure 1** provides a high-level comparison of in-person program point-in-time treatment capacity versus telehealth program availability. The in-person map highlights where local, place-based services exist, while the telehealth map reflects the state-based footprint of programs that may serve patients across state lines (with point-in-time treatment capacity distributed across served states to avoid double-counting).

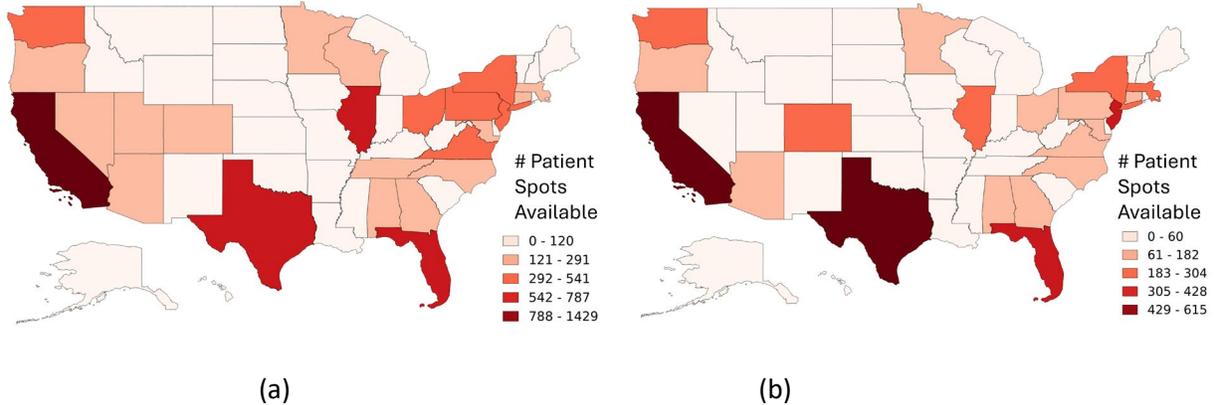


Figure 1. Number of Patient Spots Available for In-Person or Telehealth Service. (a) Total in-person EDT service program capacity by state, calculated as the total patient spots of all program slots offered by EDT centers within each state; **(b)** Telehealth EDT program availability by state (serving residents within the state or across state lines), calculated as the total patient spots of telehealth programs provided by all EDT centers that are available to residents of each state.

5.2 In-Person Treatment Capacity and EDT Deserts (Within-State Treatment Scenario)

Table 1 summarizes state-level in-person point-in-time treatment capacity by level of care (PHP, IOP, RES, IP), where values in parentheses indicate the number of individuals who can be treated at a single point in time in each setting. Across intensive levels of care, capacity is highly concentrated: for example, California (PHP 529; IOP 610; RES 220; IP 70) and Florida (PHP 236; IOP 326; RES 205; IP 20) have substantially larger in-person capacity than many other states. Beyond absolute counts, **Table 1** also illustrates clinically meaningful gaps by intensity: some states have limited or no capacity at higher-acuity levels (RES/IP). For instance, Washington shows IP = 0, and Minnesota shows IP = 0, suggesting that even in states with multiple programs, the most intensive levels of care may be unavailable locally. A concrete example is Kentucky, which has one in-person center with IOP capacity but no PHP/RES/IP capacity (PHP 0; IOP 20; RES 0; IP 0), indicating a strong constraint for patients needing higher-acuity services.

Under a within-state treatment assumption, we identify in-person EDT deserts—states/territories with no in-state in-person EDT services: Alaska, Delaware, District of Columbia, Iowa, Louisiana, Mississippi, Rhode Island, South Dakota, West Virginia, and Wyoming.

Figure 2 (top-10 ranking) and **Figure 3** (state-level choropleths) contextualize these disparities by showing that high-accessibility states cluster in a subset of regions, while many states fall into low-accessibility ranges, reinforcing that in-person access remains uneven nationwide.

States identified as having no in-state in-person EDT services include: Alaska, Delaware, District of Columbia, Iowa, Louisiana, Mississippi, Rhode Island, South Dakota, West Virginia, and Wyoming.

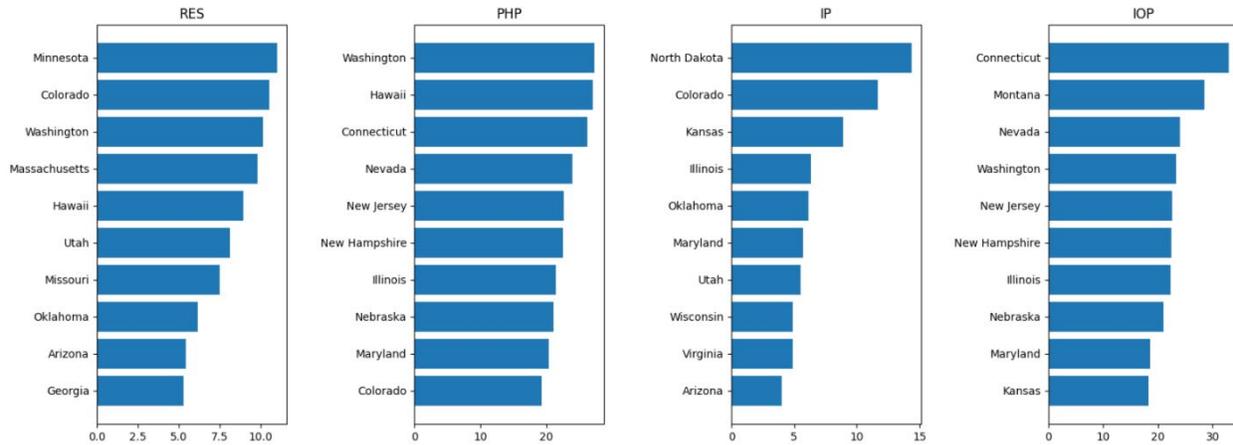


Figure 2. Top 10 states for in-person EDT accessibility. Top 10 states are ranked by the in-person accessibility score, measured as available in-person patient treatment spots per 100,000 population. Specifically, this indicator is calculated by normalizing total in-person point-in-time treatment capacity to the state population, where higher values indicate better access to in-person EDT resources relative to need (i.e., population size), providing a benchmark for comparing states with limited or no in-person services.

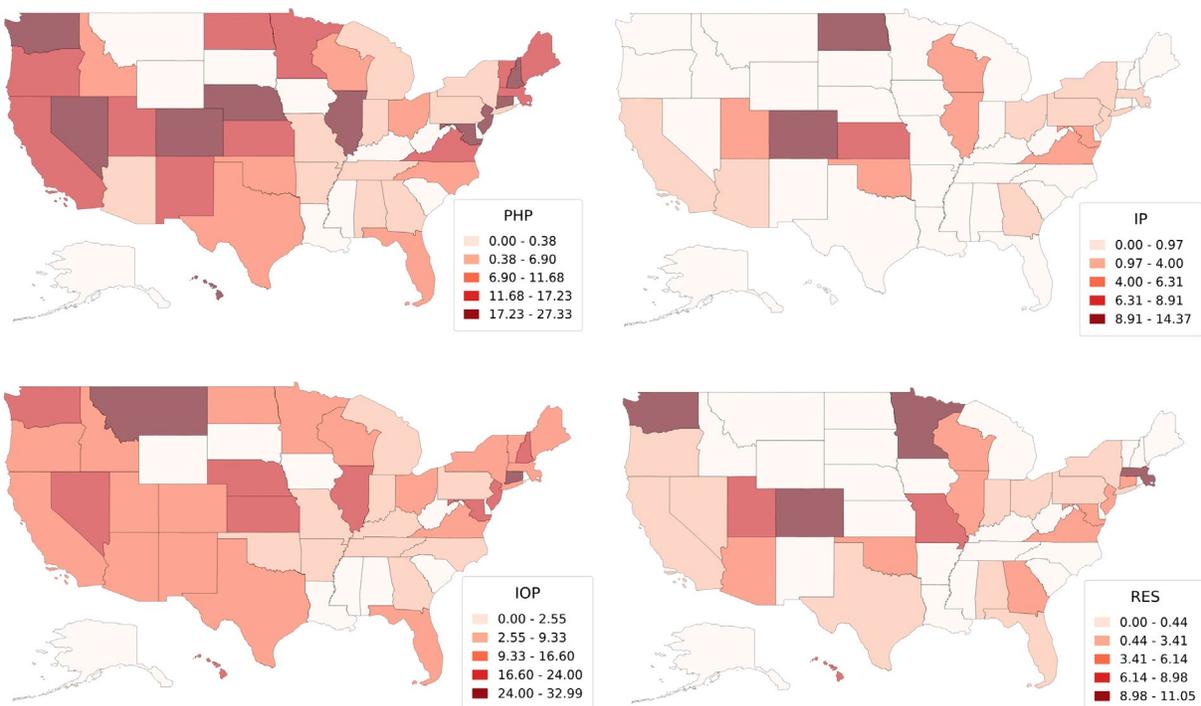


Figure 3. State-level in-person EDT accessibility map, expressed as in-person patient treatment spots per 100,000 population. Choropleth map of in-person EDT accessibility across U.S. states. The map

visualizes large geographic disparities in access, with “EDT deserts” indicate as states with **no in-state in-person EDT services** if not considering cross-state treatment.

Table 1. State-level summary of in-person eating disorder treatment (EDT) centers and estimated point-in-time treatment capacity in time by level of care (PHP, IOP, RES, IP). Values are aggregated to the state level to characterize geographic disparities in availability of higher- vs lower-intensity treatment services.

State	# of EDT centers	# of in-person patient treatment spots			
		PHP	IOP	RES	IP
California	48	529	610	220	70
Florida	26	236	326	205	20
Illinois	20	280	299	122	61
Texas	19	257	319	113	10
New York	24	150	241	120	30
New Jersey	13	193	193	40	21
Washington	12	175	174	71	0
Pennsylvania	14	130	140	41	40
Virginia	14	102	113	80	30
Ohio	8	122	122	50	30
Colorado	6	103	73	63	52
Maryland	8	122	112	21	31
Massachusetts	7	91	81	72	21
Minnesota	9	73	91	82	0
North Carolina	8	102	80	42	10
Connecticut	8	73	114	30	0
Oregon	8	82	81	50	0
Georgia	5	61	60	61	21
Arizona	5	41	81	31	21
Wisconsin	4	41	92	21	20
Nevada	3	62	62	31	10
Tennessee	7	50	60	50	0
Utah	3	51	41	41	20
Alabama	4	50	30	51	0
Oklahoma	2	40	20	30	30
Indiana	5	30	40	20	10
Missouri	4	20	50	31	0
Kansas	4	31	41	0	20
Michigan	5	30	50	0	0
Nebraska	3	40	40	0	0
Maine	2	30	30	10	0
Hawaii	2	30	20	10	0
Idaho	1	20	20	0	0
New Hampshire	1	20	20	0	0
New Mexico	1	20	20	0	0
Louisiana	1	20	0	0	10
North Dakota	1	10	10	0	10
Arkansas	1	10	10	0	0
Kentucky	1	0	20	0	0
Montana	1	0	20	0	0

Vermont	1	10	10	0	0
South Carolina	1	0	10	0	0

5.3 Telehealth capacity, cross-state coverage, and remaining “true deserts”

Telehealth services can extend reach beyond local in-person availability. As shown in the interim telehealth network visualization, some states function as cross-state telehealth hubs, with especially dense service connections originating from California. In the state-level telehealth summary (**Table 2**), telehealth capacity is highest in a small number of hub states. Values in parentheses indicate the number of individuals who can be treated at a single point in time in each level of care (PHP, IOP). For example, California (PHP 277; IOP 338), Texas (PHP 248; IOP 290), New Jersey (PHP 214; IOP 214), and Florida (PHP 187; IOP 187).

However, telehealth does not fully eliminate gaps. Even after accounting for telehealth coverage, several states remain severe EDT deserts—Alaska, Iowa, Louisiana, Mississippi, South Dakota, West Virginia, and Wyoming—indicating persistent constraints that likely require targeted service development and/or policy interventions. **Figure 4**’s telehealth accessibility map underscores that telehealth accessibility remains substantially lower than in-person accessibility in many places, suggesting limited substitution in areas with minimal infrastructure or limited program reach.

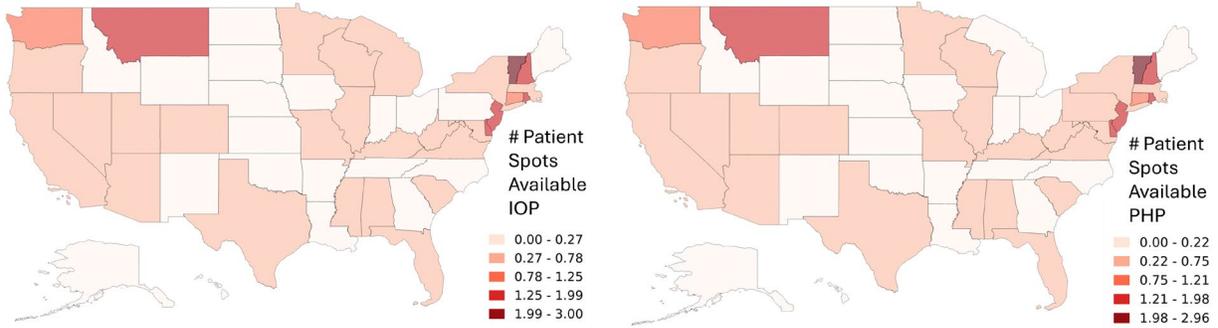


Figure 4. State-level telehealth EDT accessibility map, expressed as telehealth patient treatment spots per 100,000 population. Choropleth map of telehealth EDT accessibility across U.S. states. Telehealth expands coverage and reduces some geographic gaps, but overall accessibility remains substantially lower than in-person accessibility in many states, indicating that telehealth does not fully offset shortages of local in-person care.

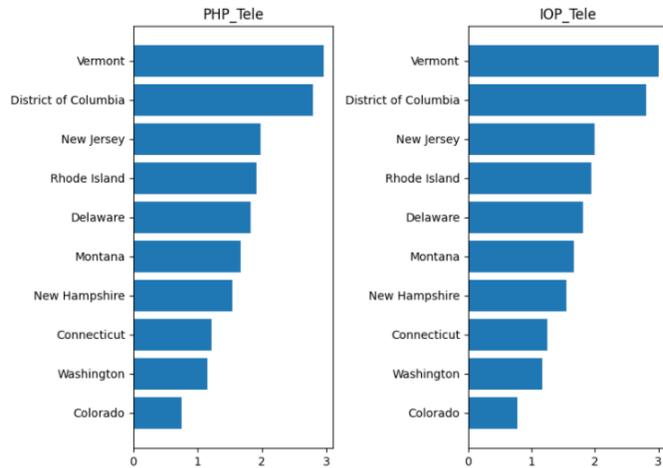


Figure 5. Top 10 states for telehealth EDT accessibility, expressed as telehealth patient treatment spots per 100,000 population. Top 10 states are ranked by the telehealth accessibility score, calculated by normalizing total telehealth point-in-time treatment capacity available to each state’s residents to the state population. The figure highlights that some states without in-person services may still receive telehealth coverage, while several states remain severe EDT deserts even after accounting for telehealth.

Table 2. State-level summary of telehealth EDT services (PHP and IOP).

State	# of EDT centers	# of telehealth patient treatment spots	
		PHP	IOP
California	18	277	338
Texas	15	248	290
New Jersey	11	214	214
Florida	10	187	187
Colorado	12	62	241
Massachusetts	9	122	182
Washington	8	145	145
Illinois	7	125	104
New York	8	91	132
Pennsylvania	7	101	81
Virginia	7	72	82
Oregon	4	82	71
Minnesota	4	63	81
Maryland	4	71	71
Ohio	3	63	63
North Carolina	6	62	50
Arizona	3	42	62
Connecticut	4	41	61
Alabama	2	42	42
Georgia	2	41	40
Tennessee	2	20	40
Michigan	2	21	31
Missouri	2	21	31

District of Columbia	1	21	21
Kentucky	1	21	21
Mississippi	1	21	21
Montana	1	21	21
New Hampshire	1	21	21
Nevada	1	21	21
Rhode Island	1	21	21
South Carolina	1	21	21
Utah	1	21	21
Vermont	1	21	21
Wisconsin	1	21	21
Maine	1	20	20
Indiana	2	10	20
Delaware	1	10	10
Kansas	1	10	10
Nebraska	1	10	10

5.4 Broadband Subscription and Telehealth Feasibility

Because telehealth requires reliable internet access, broadband subscription may constrain practical telehealth uptake in underserved regions. Several states with limited EDT resources also fall among the lowest broadband subscription rates, including Mississippi, Arkansas, New Mexico, West Virginia, and Louisiana. Here, “telehealth affordability/feasibility” is operationalized as a state’s household broadband subscription rate, calculated as the proportion of households with an active internet subscription (ACS variable B28002_002E divided by B28002_001E). **Figure 6** summarizes this context, highlighting that telehealth expansion strategies may need to be paired with digital equity investments in states where broadband access is structurally limited.

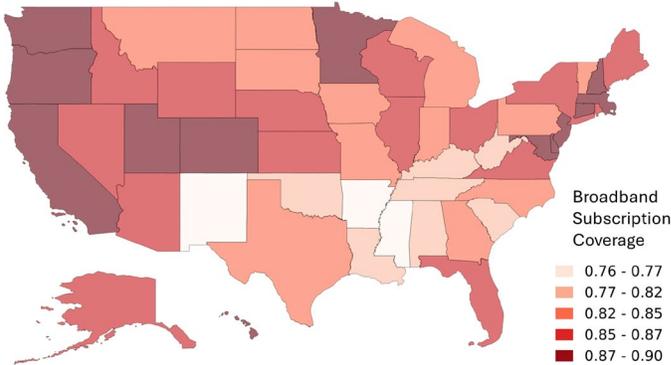


Figure 6. Telehealth affordability based on broadband subscription coverage. States with the lowest broadband subscription rates (e.g., Mississippi, Arkansas, New Mexico, West Virginia, Louisiana) may face additional barriers to benefiting from telehealth-based EDT expansion.

5.5 National Summary Indicators

Table 3 provides nationwide mean accessibility indicators for in-person and telehealth services and a telehealth affordability indicator. Accessibility is defined as the number of available treatment spots per

100,000 population, while affordability/feasibility is operationalized as the household broadband subscription rate (ACS B28002_002E/B28002_001E). Nationally, in-person accessibility is higher for outpatient-intensive modalities (e.g., IOP and PHP) than for higher-acuity services (RES/IP), while telehealth accessibility indicators are notably lower overall.

These national patterns support the interpretation that telehealth can reduce some geographic gaps but, at current levels, does not fully compensate for shortages in local in-person service availability—particularly for higher-acuity levels of care.

Table 3. Nationwide mean accessibility indices for in-person and telehealth EDT services, plus telehealth affordability indicator. Accessibility values represent point-in-time treatment capacity, expressed as the number of patient spots available per 100,000 population in each state (averaged nationwide).

	Available patient treatment spots per 100,000 population						
	In-person Accessibility				Telehealth Accessibility		
Type	RES	PHP	IP	IOP	PHP	IOP	Affordability
Nationwide Mean	3.5	11.1	2.2	12.3	0.5	0.5	0.9

6. Deliverables

Deliverables produced as part of this project include:

- A cleaned, geocoded national inventory of EDT centers with attributes on service modality and level of care.
- State-level summary tables for in-person and telehealth program availability and point-in-time treatment capacity (**Tables 1, 2 and 3**).
- National comparative maps of in-person and telehealth accessibility (**Figures 1–6**).
- A workflow-based analytic pipeline (KNIME) to compute accessibility indicators and support future disparity analyses.
- Compendium infographic PDF summarizing findings for U.S. congressional districts.
- Additional deliverables under development:
 - Web application that visualizes the results: <https://tinyurl.com/US2026EDT>. Further development and refinement of the web application are underway.
 - Public-facing report with state-specific infographics toolkit for policy advocates and policymakers.

7. Limitations

- *Directory completeness and data quality:* The Find ED Help database may not include all EDT programs. For instance, academic medical centers offering specialized EDT are not well captured in the database. The database also contains inconsistent definitions (e.g., age groups) requiring harmonization.

- *Capacity measurement uncertainty*: Program capacity indicators may not reflect real-time staffing, waitlists, or turnover, and may vary over time.
- *Telehealth constraints*: Cross-state licensure, insurance coverage, and program eligibility may limit telehealth access beyond what availability maps suggest.
- *Broadband measures*: Broadband subscription rates are a necessary but insufficient proxy for telehealth usability (e.g., device access and digital literacy also are important factors).

8. Implications and Recommendations

- Prioritize investment and service expansion in states identified as in-person EDT deserts and in states with very limited high-intensity care (RES/IP).
- Strengthen cross-state telehealth policy mechanisms (e.g., licensure pathways, reimbursement parity) to enable hub states to safely and sustainably serve underserved regions.
- Pair telehealth expansion strategies with broadband and digital equity investments in low-subscription states to ensure telehealth is feasible.
- Support ongoing data-sharing on turnover and average length of stay to improve capacity estimates and accessibility modeling precision.

9. Next Steps

Future work will incorporate additional policy and utilization inputs (e.g., tele-mental health policy and center turnover metrics) and extend analyses to finer geographic scales (e.g., Census block groups) using the 2SFCA framework and multivariable modeling to estimate disparities by urbanicity, sociodemographic characteristics, and broadband access. Dissemination plans include a peer-reviewed manuscript and, pending stakeholder review, a publicly accessible interactive mapping portal and public-facing report with state-specific infographics toolkit for policy advocates and policymakers.