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RMHP Anorexia Nervosa, Child or Adolescent: Inpatient Care

ORG_OTG: RMHP-B-016-IP-27 (BHG)

MCG Health
Behavioral
Health
Guidelines
27th Edition

Link to Codes

Care Planning - Inpatient Admission and Alternatives

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Clinical Indications for Admission to Inpatient Care

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- Admission to **Inpatient Level of Care for Eating Disorder for Child or Adolescent** (CALOCUS-CASII Level 6 - Medically Managed Residence Based Services, Composite Score 28 or more) is indicated due to **ALL** of the following [A] [B] [C] [D] (4)(6)(7)(14)(15)(16)(17)(18)(19)(20)(21)(22):
    - Patient risk and clinical condition are appropriate for inpatient treatment, as indicated by **1 or more** of the following(23):

        - Low expected body weight for height, age, and sex, and need for medical treatment of unstable physical condition and urgent refeeding are present, as indicated by **1 or more** of the following [E] (6)(7)(24)(25)(26):
            - Current rapid rate of weight loss that has created an unstable physical condition(6)(7)
            - Core body temperature less than 96 degrees F (35.6 degrees C)(27)
            - Dehydration that is severe or persistent
            - Heart rate less than 50 beats per minute daytime or less than 45 beats per minute nighttime(27)
            - Hypotension
            - Orthostatic hypotension not responsive to appropriate outpatient treatment (eg, hydration)
            - Prolonged corrected QT interval [F]
            - Severe muscle weakness [G]
            - Serum phosphorus less than 1.5 mg/dL (0.48 mmol/L) [H]
            - Electrolyte abnormality that cannot be corrected (to near normal) in emergency department or other ambulatory setting (eg, serum potassium less than 2.5 mEq/L (mmol/L), serum sodium less than 130 mEq/L (mmol/L))
            - Significant injury due to purging (eg, mucosal (Mallory-Weiss) tear, hematemesis due to ongoing frequent vomiting, colonic injury due to enema misuse)
            - Malnutrition-related severe organ dysfunction or damage findings (eg, heart failure, arrhythmia, altered mental status)
        - Imminent risk of developing significant medical instability (eg, marked vital sign abnormalities, malnourishment requiring refeeding) due to rapid rate of weight loss(6)(7)(24)

        - Supervisory needs, motivation to recover, weight-related behaviors, and comorbidities are appropriate for inpatient treatment, as indicated by **ALL** of the following:
            - Strict staff supervision of meals (may include monitoring of specialized feeding modality, such as nasogastric tube) and bathroom use (direct monitoring in bathroom) is necessary.(6)(7)(30)
            - Motivation to recover is very poor to poor (patient condition requires involuntary treatment, or if voluntary patient, highly structured, inpatient setting is necessary for adherence to care). [I] (6)(7)(30)

        - Behaviors or clinical findings (eg, weight gain pattern, food refusal, purging, medication use for weight control) are appropriate for inpatient level of care, as indicated by **1 or more** of the following [J] (6)(7)(30):
            - There has been sustained inability to achieve or maintain clinically appropriate weight goals.
            - There has been continued or renewed compensatory weight-loss behavior (eg, food refusal, self-induced vomiting, or excessive exercise). [K] [L]
            - There has been continued or renewed use of pharmaceuticals with intent to control weight (eg,

laxatives, diuretics, stimulants, or over-the-counter weight loss preparations). [K]

- Treatment services available at proposed level of care are necessary to meet patient needs and **1 or more** of the following [M] (21)(22):
  - Specific condition related to admission diagnosis is present and judged likely to further improve at proposed level of care.
  - Specific condition related to admission diagnosis is present and judged likely to deteriorate in absence of treatment at proposed level of care.
  - Patient is receiving continuing care (eg, transition of care from less intensive level of care).

- Situation and expectations are appropriate for inpatient care for child or adolescent, as indicated by **1 or more** of the following(1)(2)(3)(5)(11)(31)(32)(33):
  - Patient is unwilling to participate voluntarily in treatment and requires treatment (eg, legal commitment or order by guardian) in an involuntary unit.
  - Voluntary treatment at lower level of care is not feasible (eg, very short-term crisis intervention or residential care unavailable or insufficient for patient condition).
  - Need for physical restraint, seclusion, or other involuntary treatment intervention is present (eg, actively violent patient for whom treatment in an involuntary unit is deemed necessary in accord with applicable medical and legal criteria).
  - Around-the-clock medical and nursing care to address symptoms and initiate intervention is required; specific need is identified. [N]
  - Patient management/treatment at lower level of care is not feasible or is inappropriate (eg, less intensive level of care is unavailable or not suitable for patient condition or treatment history).
  - Biopsychosocial stressors [O] potentially contributing to clinical presentation (eg, comorbidities, [P] [Q] illness history, environment, [R] social network, ability to cope, and level of engagement [S]) have been assessed and are absent or manageable at proposed level of care.(1)(2)(3)(5)(8)(9)(10)(11)(13)(37)

Alternatives to Admission

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- Alternatives include:
  - Outpatient care. See Anorexia Nervosa: Outpatient Care.
  - Intensive outpatient program. See Anorexia Nervosa: Intensive Outpatient Program.
  - Partial hospital program. See Anorexia Nervosa: Partial Hospital Program.
  - Residential care. See Anorexia Nervosa: Residential Care.
  - Crisis intervention. See Crisis Intervention Behavioral Health Level of Care.
  - Observation behavioral health level of care. See Observation Behavioral Health Level of Care.

See Behavioral Health Levels of Care for further information.

Alternative Care Planning

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- Care planning needs for patient not requiring admission may include(6)(7)(38):
  - Treatment planning and referrals, including(4)(39):
    - Urgent appointment with psychiatrist for assessment and treatment planning(17)
    - Prompt medical care visit (eg, primary care) to assess physical health and set weight goal(40)
    - Structured family therapy(17)
    - Visits with registered dietitian for dietary planning and nutritional counseling(41)
    - Telehealth services if indicated [T] (42)
  - Discharge Planning as appropriate

- Patient, family, and caregiver education as appropriate. See Anorexia Nervosa, Child or Adolescent: Patient Education for Clinicians.

Hospitalization

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Optimal Recovery Course

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Day	Clinical Status	Interventions	Medications	Evaluation
1	• **Clinical Indications met** [U] • Social Determinants of Health Assessment • Begin Discharge planning	• Dietary plan developed [V] [W] • Monitored meals [X] [Y] • Continual observation [Z] • Supervision of bathroom use [AA]	• Possible adjunctive medication [BB]	• Exploration of admission precipitants [CC] • Psychiatric, social, medical, dietary, and substance use histories, as well as assessment of food-related or eating-disorder behaviors [DD] [EE] • Mental status and physical examinations [FF] • Laboratory tests [GG] • ECG, if clinically indicated • Assessment for refeeding syndrome • Evaluation of fall risk • Symptoms assessed multiple times per shift • Self-efficacy assessment
2	• Social Determinants of Health Assessment	• Continual observation [Z] • Monitored meals [X] [Y] • Supervision of bathroom use [AA]	• Medication review if prescribed [BB]	• **Evaluation completed and reviewed** • Weight goal set • Weight [II] • Assessment for refeeding syndrome based on physiologic status

Day	Clinical Status	Interventions	Medications	Evaluation
				• Symptoms assessed multiple times per shift
3	• **No purging (eg, self-induced vomiting), bingeing, or other problem behaviors (eg, excessive physical activity) for at least 24 hours** • **Adherent to dietary plan for at least 24 hours** • Social Determinants of Health Assessment	• **Close observation** • Monitored meals [X] [Y] • Supervision of bathroom use [AA]	• Medication review if prescribed [BB]	• Weight [II] • Assessment for refeeding syndrome based on physiologic status • Symptoms assessed multiple times per shift
4	• **Rate of weight gain is acceptable** [KK] [LL] • Social Determinants of Health Assessment	• **Close observation** • Dietary plan reviewed and revised as necessary • Monitored meals [X] [Y] • Possible supervision of bathroom use [AA]	• Medication review if prescribed [BB]	• Weight [II] • Assessment for refeeding syndrome based on physiologic status • Symptoms assessed at decreasing frequency with clinical improvement • Self-efficacy assessment • Transition to patient check-in with staff
5	• **Rate of weight gain is acceptable** [KK] [LL] • Social Determinants of Health Assessment	• **Close observation at reduced intensity** • Dietary plan reviewed and revised as necessary • Monitored meals [X] [Y]	• Medication review if prescribed [BB]	• Weight [II] • Assessment for refeeding syndrome based on physiologic status • Transition to patient check-in with staff

Day	Clinical Status	Interventions	Medications	Evaluation
		• Possible supervision of bathroom use [AA]		
6	• **Rate of weight gain is acceptable** [KK] [LL] • Social Determinants of Health Assessment	• **No need for close observation** • Dietary plan reviewed and revised as necessary • Monitored meals [X] [Y] • Possible supervision of bathroom use [AA]	• Medication review if prescribed [BB]	• Weight [II] • Assessment for refeeding syndrome based on physiologic status • Patient check-in only
7	• **Adequate adherence to dietary plan for next level of care** • **Purging, bingeing, and other problem behavior absent or manageable/treatable at available lower level of care** • **Rate of weight gain is acceptable** [KK] [LL] • **Physical status acceptable** [MM] • **Patient and supports understand follow-up treatment and crisis plan** • **Provider and supports sufficiently available at lower level of care** • **Patient can participate (eg, verify absence of plan for harm) in needed monitoring** • **Medical comorbidities, adverse medication events, and substance use**	• Review follow-up treatment and crisis plan with patient and supports [NN]	• Medication review if prescribed [BB]	• Weight [II]

Day	Clinical Status	Interventions	Medications	Evaluation
	absent or manageable/treatable at available lower level of care • Social Determinants of Health Assessment • Complete Discharge planning • Discharge			
(6)(7)(14)(17)(41)(45)(49)(53)(56)(57)(58)(59)(60)				

Recovery Milestones are indicated in **bold**.

Goal Length of Stay: 6 days

Extended Stay

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Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Extended stay beyond goal length of stay may be needed for(6)(7)(58):
  - Persistent self-induced vomiting or excessive exercise
    - Expect prompt reassessment steps, including:
      - Identification of precipitants of purging, including:
        - Concerns about edema or other bodily changes
        - Dissatisfaction with food choices
        - Psychosocial conflict
      - Review of dietary plan with patient's input
      - Review of plan for monitoring patient during and after meals [X] [Y]
      - Review of behavioral management plan if applicable [OO]
      - Repeat serum electrolytes
    - Anticipate treatment measures, including as appropriate:
      - Interventions to address psychosocial precipitants of behavior
      - Supervision of bathroom use
      - Initiation or modification of behavioral management plan [OO]
    - Expect brief to moderate stay extension.
  - Delay in achieving targeted weight gain
    - Expect prompt reassessment steps, including:
      - Review of dietary plan with patient's input
      - Identification of reasons for any food refusal, including:
        - Abdominal discomfort due to delayed gastric emptying
        - Concerns about edema or other bodily changes
        - Dissatisfaction with food choices
        - Psychosocial conflict
      - Determination if patient is secretively vomiting or exercising
      - Review of behavioral management plan if applicable [OO]
      - Evaluation of therapeutic alliance

            - Anticipate treatment measures, including as appropriate:
                - Interventions to address psychosocial conflicts
                - Measures to address self-induced vomiting
                - Addition of supplemental liquid feeding formula
                - Initiation or modification of behavioral management plan [OO]
                - NG feeding [PP]
            - Expect brief to moderate stay extension.
        - Delay in stabilizing physical state(62)
            - Expect prompt reassessment steps, including:
                - Assessment of adequacy of rate of weight gain
                - Consideration of possibly contributing medical comorbidities
            - Anticipate treatment measures, including as appropriate:
                - Measures to attain acceptable rate of weight gain
                - Treatment of any identified medical comorbidity
            - Expect brief to moderate stay extension.

Hospital Care Planning

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- Evaluation and care needs may include(56):
    - Diagnostic test scheduling and completion, including:
        - Laboratory tests [GG]
        - ECG(49)
        - Psychological testing to evaluate cognitive function, personality dynamics, psychosis [QQ]
        - Bone densitometry [RR]
    - Treatment and procedure scheduling and completion, including(39):
        - Psychosocial interventions emphasizing admission precipitants and barriers to discharge [HH]
        - Clinical management and psychoeducation [JJ]
        - Possible adjunctive medication
        - Dietary planning and nutritional counseling(41)
        - Parental component of psychosocial interventions(17)
        - Structured family therapy [SS] (17)
        - NG feeding or parenteral nutrition [PP]
    - Consultation, assessment, and other services scheduling and completion, including:
        - Substance use disorder assessment
        - Conference with school
        - Social services consultation for placement or housing
        - Telehealth services if indicated [T] (42)
    - Monitoring patient's status for deterioration and comorbid conditions, including:
        - Exacerbation of depression, anxiety, oppositionality, suicidal ideation(68)
        - Upper abdominal discomfort due to delayed gastric emptying [TT]
        - Peripheral edema due to refeeding or withdrawal from laxatives or diuretics
        - Constipation due to refeeding or laxative cessation
        - Refeeding syndrome [UU]
- See Inpatient Monitoring and Assessment Tool, as appropriate.

Discharge

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Discharge Planning

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[**Expand All** / **Collapse All**]

- Discharge planning includes [VV] :
    - Assessment of needs and planning for care, including(70):
        - Develop treatment plan (involving multiple providers as needed).

        - Evaluate and address preadmission functioning as needed.
        - Evaluate and address psychosocial status issues as indicated. See Psychosocial Assessment for further information.
        - Evaluate and address social determinants of health (eg, housing, food). See Social Determinants of Health Screening Tool for further information.(69)
        - Evaluate and address patient or caregiver preferences as indicated.
        - Identify skilled services needed at next level of care, with specific attention to:
            - Development of individualized age-appropriate plan of care, including dietary counseling and weight checks(71)
            - Nutrition and hydration management(17)
            - Psychosocial assessment, management, and referrals(72)
    - Early identification of anticipated discharge destination; options include(73)(74):
        - Home, considerations include:
            - Access to follow-up care
            - Home safety assessment. See Home Safety Assessment for further information.
            - Self-management ability if appropriate. See Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment for further information.
            - Caregiver need, ability, and availability
        - Post-acute skilled care or custodial care as indicated. See Discharge Planning Tool for further information.
    - Transitions of care plan complete, including(74):
        - Patient and caregiver education complete. See Anorexia Nervosa, Child or Adolescent: Patient Education for Clinicians for further information.
            - See Teach Back Tool for further information.

        - Medication reconciliation complete
        - Plan communicated to patient, caregiver, and all members of care team, including(78)(79):
            - Inpatient care and service providers
            - Primary care provider
            - All post-discharge care and service providers
        - Appointments planned or scheduled, which may include(56):
            - Primary care provider
            - Behavioral health provider(80)
            - Dietitian(80)
            - Psychiatrist
            - Specialists for management of comorbidities as needed
            - Other
        - Outpatient testing and procedure plans made, which may include(56):
            - Bone densitometry(81)
            - Laboratory testing(71)(81)
            - Other
        - Referrals made for assistance or support, which may include:
            - Alcohol and other drug abuse or dependence treatment
            - Behavioral health services (eg, counseling)(71)(80)
            - Community services
            - Educational program (eg, chronic condition management, self-management)(71)
            - Financial, for follow-up care, medication, and transportation
            - Self-help or support groups
            - Social services (eg, social programs, advance directives)
            - Tobacco use treatment
            - Other
        - Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:
            - Nutritional supplements(81)
            - Other

Discharge Destination

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Usual

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- Intensive outpatient program. [WW] See Anorexia Nervosa: Intensive Outpatient Program.

Alternate

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- Outpatient care. See Anorexia Nervosa: Outpatient Care.
- Partial hospital program. See Anorexia Nervosa: Partial Hospital Program.
- Residential care. See Anorexia Nervosa: Residential Care.

See Behavioral Health Levels of Care for further information.

Evidence Summary

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Background

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Anorexia nervosa has a highly variable and often chronic course, with a mean onset of 16 to 17 years of age.(4)(17)(18)(38)(51) **(EG 2)** During an acute onset or exacerbation of symptoms, the principal goal of treatment is restoration of normal nutritional intake and BMI.(38)(82) **(EG 2)** Patients with this disorder have an increased risk of death due to the physical consequences of malnutrition and purging, as well as an increased incidence of suicide.(83)(84)(68) **(EG 2)**

Length of Stay

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Analysis of national hospital discharge data shows 30% of hospitalized pediatric patients (younger than 18 years of age) with the principal diagnosis of anorexia nervosa discharged in 6 days or fewer.(58) **(EG 3)**

Treatment

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Pharmacotherapy: Despite an absence of high-quality data supporting the effectiveness of pharmacotherapy in the treatment of anorexia nervosa, medications are often prescribed for this purpose.(85)(86)(87) **(EG 2)** Systematic reviews have failed to find consistent evidence that any medication improves the rate of weight gain during treatment; study limitations included short study duration and a high dropout rate.(17)(47)(48)(88) **(EG 1)** Systematic reviews and meta-analyses of randomized controlled trials examining the role of atypical antipsychotics in the treatment of anorexia nervosa have not found support for their effectiveness in achieving significant increases in BMI or alleviating other symptoms of anorexia.(89)(90)(91) **(EG 1)** A practice parameter on the treatment of eating disorders in adolescents recommends that the use of medications should be limited to patients with comorbid conditions or refractory cases.(14) **(EG 2)**

Psychosocial therapy: A practice parameter for the treatment of eating disorders in adolescents recommends outpatient psychosocial interventions as the initial treatment of choice.(14) **(EG 2)** Systematic reviews of the treatment of anorexia nervosa in adolescents have found that the most effective treatments are structured family therapies, typically administered during 10 to 40 sessions over 6 to 12 months, as this approach involves both patient and parents (either conjointly or separately) and encourages parents to take an active role in normalizing the patient's eating routines.(92) **(EG 1)** A systematic review and meta-analysis of psychotherapy in the treatment of adolescents with anorexia nervosa (3 randomized controlled trials, 183 patients) found that while there were no significant differences between individual therapy and family-based therapy at the end of treatment, family-based

therapy was superior at 6-month to 12-month follow-up.(93) **(EG 1)** Reviews of the treatment of eating disorders indicate that family treatment models, and family-based treatment in particular, represent the best evidence-based approach for adolescents with anorexia nervosa.(85)(94) **(EG 2)** A pragmatic randomized multicenter trial of multi-family and single-family therapy for adolescent patients with anorexia nervosa (169 adolescents) reported benefits for more than 75% of participants in the multi-family group and nearly 60% of participants in the single-family arm at 12 months.(95) **(EG 1)** A randomized controlled trial of family-based treatment vs systemic family therapy for adolescents with anorexia nervosa (158 participants) found similar hospitalization rates in the first 5 weeks of treatment, but subsequently patients assigned to the family-based intervention had a leveling off of days of inpatient admission, while patients in the systemic family group had an increase in the number of inpatient days.(96) **(EG 1)** A randomized controlled trial of 107 adolescents with anorexia nervosa found that remission rates at the end of treatment were significantly higher for parent-focused outpatient treatment as compared with family-based outpatient treatment. However, at 6-month and 12-month follow-up, the remission rates between the 2 forms of treatment were not significantly different.(97) **(EG 1)**

Level of Care

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A systematic review and meta-analysis of different treatment settings in anorexia nervosa (5 studies: inpatient, partial hospital, outpatient) found no difference in treatment outcomes between different treatment settings and different lengths of inpatient treatment.(21)(98) **(EG 1)** Indications for inpatient care may include severe weight loss that is refractory to appropriate treatment in alternative settings, refusal to eat, life-threatening physical complications of malnutrition such as cardiac dysrhythmias, or an imminent risk of suicide or serious self-harm.(17)(21)(22)(47)(99)(100)(101) **(EG 1)** Rarely, tube feeding or parenteral nutrition may be necessary and generally is provided in an inpatient setting.(61) **(EG 2)** Within the inpatient setting, a randomized controlled trial of 111 adolescents and young adults found that refeeding at 2000 kcal/day (8374 kJ/day) and increasing by 200 kcal/day (837 kJ/day) led to significantly earlier medical stability and shorter length of stay while not showing increased adverse effects related to refeeding (eg, electrolyte abnormalities) as compared with a lower calorie refeeding protocol beginning at 1400 kcal/day (5862 kJ/day) and increasing by 200 kcal/every other day (837 kJ/every other day). Both higher and lower calorie refeeding groups did not differ over 1-year follow-up in medical hospitalization rates, number of rehospitalizations, and number of days rehospitalized.(43)(44) **(EG 1)** A systematic review and meta-analysis including 9 studies of compulsory treatment in 242 adolescents and adults with anorexia nervosa found that patients treated compulsorily had a lower BMI at baseline and required longer length of stay but had similar outcomes as patients treated voluntarily.(102) **(EG 1)** A review including 8 studies and 3 guidelines on the use of bed rest in the inpatient treatment of adolescents and adults with severe anorexia nervosa found insufficient evidence to support the routine use of bed rest in treatment. Due to the potential for physical and psychological harm, the researchers concluded that intensive nursing support focusing on engagement and adequate dietary intake be employed instead of bed rest.(103) **(EG 2)** A systematic review of randomized controlled trials of add-on treatments (pharmacotherapy and psychosocial interventions) during inpatient care failed to find support for most of these strategies for increasing weight recovery during acute inpatient admission.(20) **(EG 1)** Practice guidelines for the treatment of patients with eating disorders indicate that the decision for treatment of a patient with an eating disorder at a given level of care should be made on an individual basis, taking into account the patient's personal weight status, rate of weight change, risk of developing medical complications, need for and frequency of weight monitoring, comorbidities, motivation, facility-based or home-based supervisory needs, and other psychological, behavioral, and social factors.(6)(7)(13)(17)(24) **(EG 1)** In a randomized controlled trial (121 participants) that compared family-based treatment and adolescent-focused individual therapy in adolescents with anorexia, family-based treatment reduced hospitalization rates during treatment.(104) **(EG 1)**

Patients with significant weight loss refractory to appropriate outpatient care who need around-the-clock behavioral care but do not need around-the-clock medical or nursing services may appropriately receive treatment at a residential care facility.(6)(7)(17) **(EG 2)** Treatment in a partial hospital program represents an alternative to inpatient care for patients with significant weight loss that is refractory to appropriate outpatient care who need professionally supervised meals but do not need around-the-clock skilled nursing or medical care.(6)(7)(17) **(EG 2)** Partial hospital programs (also known as day hospitals) provide multidisciplinary behavioral care for 6 to 8 hours per day, 5 to 7 days per week, and are staffed in a manner similar to the day shift of an inpatient unit.(13) **(EG 2)** They typically provide some form of mealtime supervision, and a weight gain contract is often a contingency for continued

participation in the program.(105) **(EG 2)** Partial hospital programs and residential care may serve to transition patients from inpatient to outpatient care.(6)(7)(17) **(EG 2)** As compared with inpatient treatment, partial hospital programs are less restrictive and allow the adolescent patient to continue contact with family, school, and peers.(106) **(EG 2)** A retrospective study of 326 patients (age 8 to 21 years, most diagnosed with anorexia nervosa) treated in partial hospitalization programs found that patients who se treatment included family-based therapy had lower rates of readmission in 3 years of follow-up as compared with patients treated in a partial hospitalization program that did not include family-based intervention.(107) **(EG 2)** Observational studies of partial hospital programs for eating disorders have demonstrated treatment efficacy in achieving weight gain.(108)(109) **(EG 2)** A randomized controlled trial compared continued inpatient care and discharge to day-patient treatment in the care of adolescents undergoing their first hospital admission for anorexia nervosa and found similar efficacy for weight restoration and maintena nce in both venues of care.(110) **(EG 1)** A study of day hospital psychodynamic psychotherapy for patients with severe anorexia nervosa found this level of care was associated with improvements in psychopathology that were seen at the end of treatment and were maintained at 12-month follow-up.(111) **(EG 2)** Intensive outpatient programs, which typically provide 3 to 4 hours of psychosocial treatment, 1 to 4 days per week (usually 6 to 12 hours of treatment per week), mostly by using a group format, are intended for circumstances in which a patient needs a type or frequency of treatment that is not available in a standard outpatient setting.(13) **(EG 2)** Specialized intensive outpatient treatment for anorexia may be an appropriate entry point or step-down level of care for motivated patients with less severe symptoms who require more intensive maintenance support over a longer term, as such programs may p rovide an otherwise unavailable therapy with demonstrated effectiveness (eg, structured family therapy) and/or multidisciplinary team-based coordinated services, which are recommended by guidelines as best practice.(6)(7)(17) **(EG 2)** For patients impaired to a degree that requires inpatient care, outpatient or maintenance care follow-up is unlikely to be successful in many treatment delivery systems. Even for well-supported, motivated patients whose symptoms are of short duration, major guidelines suggest that best practice follow-up care includes specialized services that are relatively intensive, multidisciplinary, team-based, and coordinated.(6)(7)(17) **(EG 2)**

Remission and Relapse

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Many patients with anorexia nervosa experience a chronic disease course that varies in severity over time; young age at onset and short duration of illness are associated with better long-term outcomes, whereas longer duration of illness and medical or psychiatric comorbidity are associated with worse outcomes.(112)(113) **(EG 2)** Relapse rates of 9% to 42% are reported, with at least part of this range due to differences in definition.(114) **(EG 2)** Remission rates (partial and full) also are variable, ranging from 13% to 89%, with the highest reported rates seen in adolescents.(115)(116) **(EG 1)** Structured family therapy for adolescents is reported to have higher remission rates, with up to 67% of patients in remission after 6 to 18 months of therapy.(117) **(EG 1)** A follow-up study of patients who had completed a randomized controlled trial of family-based therapy vs adolescent-focused individual therapy (2-year and 4-year follow-ups were completed) found that among patients who achieved full remission, remission remained stable with few relapses in longer-term follow-up regardless of treatment type.(118) **(EG 2)** Long-term follow-up studies of structured therapies for adults and adolescents have found that the weight gains may be maintained for at least 1 to 5 years after the end of treatment.(17)(66)(119) **(EG 1)** A retrospective review of the long-term efficacy of short-term (5-day) intensive family therapy for adolescent eating disorders (74 patients) found that over a 30-month follow-up, 88% of patients achieved either full (61%) or partial (27%) remission.(120) **(EG 2)** Maintenance treatment may not be necessary in children and adolescents who achieve full remission, especially if this goal is attained early in the course of the disease.(66) **(EG 2)** Relapse rates in adults in general, as well as in adolescents and children with longstanding disease, are much higher, and these patients may require ongoing care.(66)(119) **(EG 2)**

Policy History

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7/13/2023 - Modified 25th edition MCG guideline by removing BMI from clinical indications as required by new legislation Colorado Revised Statute CRS 10-16-166 and Senate Bill 23-176, effective date 7/1/2023.

11/7/2023 - Upgraded to 27th edition MCG with BMI removed from clinical indications.

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Colorado Revised Statute CRS 10-16-166 and Senate Bill 23-176.

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Footnotes

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[A] Inpatient psychiatric units generally are locked, equipped to restrain or seclude patients for safety if necessary, and staffed by nurses around the clock. Attending physicians typically round at least 5 days per week, and a covering physician always is available to see a patient on site.(1)(2)(3)(4)(5) [A in Context Link 1]

[B] Whether or not a patient with an eating disorder should be hospitalized on a psychiatric vs a general medical or pediatric/adolescent unit depends on a variety of factors, including medical and psychiatric status, skills and abilities of staff in the proposed admitting institution, and the availability of suitable programs to address medical and psychiatric needs. There is some evidence to suggest that when hospital admission is necessary, admission to inpatient units specializing in eating disorder treatment may be associated with better outcomes.(6)(7) [B in Context Link 1]

[C] The purpose of the care guidelines is to promote evidence-based care across the continuum of care to enhance the delivery of quality healthcare. Indications are presented for different levels of care. These indications help define the optimal level of care and can assist in developing alternatives to higher levels of care, tracking patient progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for transition of patients from one level of care to another. Relevant professional society guidelines are foundational content for evaluation and treatment of behavioral health disorders at different levels of care and are complemented by the best available published evidence.(1)(2)(3)(8)(9)(10)(11)(12)(13) [C in Context Link 1]

[D] Composite score does not replace clinical judgment and is meant as a guide to assist in determining needed level of care. Extreme risk of harm, severe functional impairment, or severe comorbidity may independently necessitate placement at inpatient level of care.(1)(2)(3) [D in Context Link 1]

[E] Practice guidelines for the treatment of patients with eating disorders indicate that the decision for hospitalization of a patient with an eating disorder should be made on an individualized basis, utilizing a patient's personal weight status and risk of developing medical complications, instead of using standardized cutoff levels for BMI, rate of weight change, or percentage of healthy body weight.(24) [E in Context Link 1]

[F] QT-interval prolongation is a possible complication of anorexia nervosa and a suspected contributor to the increased incidence of sudden death observed in patients with this disorder.(28) [F in Context Link 1]

[G] Muscle weakness is considered severe if it prevents the patient from rising from a seated position without use of the arms, or rising from a supine position even with use of the arms, or from being able to sit up at all.(17) [G in Context Link 1]

[H] Total body phosphorus depletion, a possible consequence of malnutrition, increases the risk (during nutritional rehabilitation) of refeeding syndrome, a condition involving severe alterations in fluid and electrolyte balances that can lead to potentially life-threatening cardiac and neuromuscular complications.(27)(29) [H in Context Link 1]

[I] A practice guideline for the treatment of patients with eating disorders indicates that an assessment of motivation to recover is indicated in the initial admission assessment to assist in determining the appropriate level of care to treat the eating disorder.(6)(7) [I in Context Link 1]

[J] Patients appropriate for inpatient eating disorder treatment may be preoccupied with intrusive or repetitive thoughts for more than 6 hours a day.(6)(7) [J in Context Link 1]

[K] A practice guideline for the treatment of patients with eating disorders indicates that patients engaged in and unable to control multiple daily episodes of purging behaviors that are severe, persistent, and disabling, and who have been unable to regulate these behaviors despite appropriate trials of outpatient care may be considered for inpatient management. This is the case even in the absence of metabolic abnormalities, provided that they otherwise meet inpatient admission criteria related to supervisory needs, motivation, and comorbidities.(6)(7) [K in Context Link 1, 2]

[L] A practice guideline for the treatment of patients with eating disorders indicates that compulsive exercising rarely is a sole indication for increasing level of care.(6)(7) [L in Context Link 1]

[M] Assessment of the likelihood of benefit at the proposed level of care may help identify subgroups of patients who may be more likely to respond to particular treatments and help optimize the care plan to increase the likelihood of successful recovery. It may also help determine if a specialized treatment setting (eg, dual-diagnosis program) or a different level of service intensity would be more appropriate to address the patient's needs.(1)(2)(3)(6)(7)(9) [M in Context Link 1]

[N] Examples of medical conditions appropriate for inpatient care include conditions that require intensive, around-the-clock medical monitoring and daily nursing interventions, or patients with significant metabolic or ECG abnormalities related to vomiting.(1)(2)(3) [N in Context Link 1]

[O] Biopsychosocial stressors may impact the level of care necessary to manage a psychiatric or behavioral condition, including the ability of the program to meet comprehensive patient needs, ensure treatment adherence, enhance motivation, or prevent relapse (ie, comorbidities, environmental factors, or other barriers may prevent effective treatment at a less intensive level of care than might otherwise be appropriate to the patient's condition). Biopsychosocial assessment factors should be incorporated into care planning,

including planned treatment goals, and intensity and duration of interventions. Any identified deficits should be manageable by the program directly or through alternative arrangements.(1)(2)(3)(8) [O in Context Link 1]

[P] Comorbid conditions may directly impact the experience of psychiatric symptoms (eg, COPD and anxiety), or may indirectly impact determination of the appropriate venue for care (eg, routine blood sugar and insulin management in people with diabetes). If clinically appropriate, testing related to diagnosis or management (eg, screening for liver and kidney function, hepatitis, HIV, syphilis, tuberculosis) may be performed off-site.(1)(2)(3)(8) Assessment and treatment of co-occurring medical and/or developmental conditions through services and treatment settings capable of rendering integrated care is recommended.(1)(2)(3)(8)(10)(11)(34) The level that comorbid medical and/or developmental conditions are present may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care).(1)(2)(3)(8)(35) [P in Context Link 1]

[Q] Evaluation/assessment and treatment of co-occurring substance use disorders through services and treatment settings capable of rendering integrated care is recommended.(1)(2)(3)(8)(10)(34) The level that comorbid substance use disorders contribute to the primary presenting condition may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care or specialty dual-diagnosis program).(1)(2)(3)(8)(35) [Q in Context Link 1]

[R] The degree of environmental stressors and amount of support in the patient recovery environment should be considered in the context of the clinical presentation in determining the appropriate level of care for treatment. The level of environmental stressors may be low, mild, moderate, high, or extreme. The level of support in the environment may range from absent or minimal to limited to supportive or highly supportive.(1)(2)(3)(8)(10)(11)(34)(35) [R in Context Link 1]

[S] Participation motivated by a wish to avoid negative consequences rather than accept the need to work toward recovery may require more intense monitoring and follow-up.(9)(35)(36) The patient's level of engagement may be described on a continuum: optimal, positive, limited, minimal, or unengaged. Readiness to change may range from actively and willingly engaged to unable to follow treatment recommendations due to clinical condition.(1)(2)(3)(8)(35) [S in Context Link 1]

[T] Telehealth may improve access to and coordination of mental health care. Patients with behavioral health diagnoses may use telehealth or telepsychiatry to access mental health support or care (eg, to get assistance with problem-solving techniques or ask about presenting symptoms or medication use).(42) [T in Context Link 1, 2]

[U] See Clinical Indications for Admission to Inpatient Care in this guideline. [U in Context Link 1]

[V] For patients whose preadmission intake has been insufficient to support weight gain, refeeding generally begins at 30 to 40 kcal/kg (126 to 167 kJ/kg) per day, or alternatively, at 200 to 300 kcal (837 to 1256 kJ) above preadmission intake, and is advanced as appropriate to achieve a weight gain of 1 to 3 lb (0.5 to 1.4 kg) per week while the patient is in inpatient care. In addition, multivitamin and mineral supplements are usually indicated.(6)(7) [V in Context Link 1]

[W] A randomized controlled trial of 111 adolescents and young adults found that refeeding at 2000 kcal/day (8374 kJ/day) and increasing by 200 kcal/day (837 kJ/day) led to significantly earlier medical stability and shorter length of inpatient stay while not showing increased adverse effects related to refeeding as compared with a lower calorie refeeding protocol beginning at 1400 kcal/day (5862 kJ/day) and increasing by 200 kcal/every other day (837 kJ/every other day). Both higher and lower calorie refeeding groups did not differ over 1-year follow-up in medical hospitalization rates, number of rehospitalizations, and number of days rehospitalized.(43)(44) [W in Context Link 1]

[X] Monitored meals means meals and snacks are given under the supervision of trained staff members who demonstrate empathy and understanding, while setting firm limits about what must be consumed.(45) [X in Context Link 1, 2, 3, 4, 5, 6, 7]

[Y] Provision of meal supervision from time of admission through discharge has been associated with shorter lengths of stay as compared to patients who only receive meal supervision on an as needed basis.(46) [Y in Context Link 1, 2, 3, 4, 5, 6, 7]

[Z] Continual observation may be necessary to prevent a patient from exercising more than is appropriate, given the patient's caloric intake and physical condition.(6)(7) [Z in Context Link 1, 2]

[AA] Patients with a history of self-induced vomiting may need to be supervised while using the bathroom, especially during the hour after each meal.(6)(7) [AA in Context Link 1, 2, 3, 4, 5, 6]

[BB] Adjunctive medication (eg, for symptoms due to refeeding) may be appropriate in acute situations.(47)(48) [BB in Context Link 1, 2, 3, 4, 5, 6, 7]

[CC] Precipitants explain why the admission occurred at the specific point in time.(14) [CC in Context Link 1]

[DD] Medical history should include documentation of last menstrual period.(49) [DD in Context Link 1]

[EE] Assessment of food-related or eating-disorder behaviors should include weight history and attitudes, beliefs, and perceptions regarding food, weight, and body shape.(6)(7)(49) When available, outside observations (eg, by family members) should be included in the assessment.(49) [EE in Context Link 1]

[FF] History and examination should include determination of body mass index (BMI) as well as date of last menstrual period.(49) [FF in Context Link 1]

[GG] Laboratory tests that are generally indicated as part of the initial assessment of patients with eating disorders include CBC, urinalysis, complete metabolic profile (including phosphorus and magnesium), creatinine, thyroid function testing, and (fasting) glucose.(49) Elevated aminotransferases are common in patients with anorexia nervosa due to malnutrition-induced hepatitis and can also be seen in the setting of refeeding. With supervised refeeding and return to a healthy body weight, aminotransferase levels often normalize quickly. Routine laboratory testing, imaging, and liver biopsy are unnecessary unless there is high clinical suspicion for a secondary cause of liver dysfunction.(50) [GG in Context Link 1, 2]

[HH] Psychosocial interventions should be individualized, address all admission precipitants and barriers to discharge, and involve family and other supports as necessary.(33)(51)(52) [HH in Context Link 1, 2, 3, 4, 5, 6, 7]

[II] The patient should be weighed at the same time each day, wearing the same type of garment, immediately after voiding.(6)(7) [II in Context Link 1, 2, 3, 4, 5, 6]

[JJ] Clinical management should include discussion of psychological and physical consequences of refeeding (eg, anxiety regarding changes in body shape, abdominal discomfort due to reduced gastrointestinal motility).(6)(7) [JJ in Context Link 1, 2, 3, 4, 5, 6]

[KK] For patients admitted because of physical risk due to malnutrition or failure to gain weight at a lower level of care, an acceptable rate of weight gain is at least 2 lb (0.9 kg) per week.(6)(7)(17) For patients admitted primarily to manage/treat risk of suicide or serious self-harm, absence of weight loss is acceptable. [KK in Context Link 1, 2, 3, 4]

[LL] Among patients undergoing weight restoration in a controlled inpatient setting, the rate of weight gain was significantly associated with short-term clinical outcome after discharge.(53) [LL in Context Link 1, 2, 3, 4]

[MM] Physical status is acceptable if any physiologic instability, electrolyte abnormality, dehydration, or physical complication (eg, esophageal damage) is absent or can be safely managed/treated at an available lower level of care.(17) [MM in Context Link 1]

[NN] A crisis or safety plan establishes what actions the patient and supports are to take if food refusal, purging, or dangerous ideation or behavior develops or worsens.(54)(55) [NN in Context Link 1]

[OO] A behavioral management plan uses positive reinforcements (eg, privileges) and negative reinforcements (eg, exercise restriction) to encourage adherence to the patient's dietary plan and restraint from purging.(6)(7) [OO in Context Link 1, 2, 3, 4]

[PP] NG or parenteral feeding may be necessary if sufficient nutrient intake cannot be achieved by using less intrusive means, including modification of the patient's dietary plan, addition of supplemental feeding formula, initiation of a behavioral ma nagement plan, and addressing psychosocial precipitants to food refusal.(6)(7)(61) [PP in Context Link 1, 2]

[QQ] Routine assessment upon admission is not indicated.(10) Testing that would not affect or contribute substantially to a diagnosis or treatment plan is inappropriate.(63)(64) [QQ in Context Link 1]

[RR] Assessment of bone density using dual-energy x-ray absorptiometry is recommended for females who have been amenorrheic for more than 6 to 12 months and should be included in outpatient care planning.(6)(7)(65) [RR in Context Link 1]

[SS] For adolescents with anorexia nervosa, best evidence suggests that the most effective treatments are structured family therapies, typically administered during 10 to 40 sessions over 6 to 12 months, that involve both patient and parents.(17) Longer-duration therapy (20 sessions over 12 months vs 10 sessions over 6 months) may be more beneficial for adolescents with very severe symptoms.(66)(67) [SS in Context Link 1]

[TT] Upper abdominal discomfort due to delayed gastric emptying may be remedied by exchanging a portion of the solid food in a patient's diet for liquid feeding formula.(6)(7) [TT in Context Link 1]

[UU] Refeeding syndrome can develop in severely malnourished patients who are refed too rapidly and can lead to severe fluid and electrolyte imbalances and life-threatening cardiac and neuromuscular complications.(6)(7) [UU in Context Link 1]

[VV] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(69) [VV in Context Link 1]

[WW] For patients impaired to a degree to require inpatient care, outpatient or maintenance care follow-up is unlikely to be successful in many treatment delivery systems. Even for well-supported, motivated patients whose symptoms are of short duration, major guidelines suggest that best-practice follow-up care includes specialized services that are relatively intensive, multidisciplinary, team-based, and coordinated.(6)(7)(17) [WW in Context Link 1]

Codes

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ICD-10 Diagnosis: F50.00, F50.01, F50.02, R63.4, R63.6

DSM-5: F50.01, F50.02