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RMHP Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Child or Adolescent: Inpatient Care

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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 Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Outpatient Care.
  - Intensive outpatient program. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Intensive Outpatient Program.
  - Partial hospital program. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Partial Hospital Program.
  - Residential care. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: 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(38):
    - Treatment planning and referrals(39):
        - Prompt visit to psychiatrist and possible medication management for:
            - Bulimia nervosa
            - Binge-eating disorder
            - Other specified feeding or eating disorders
        - Referral for structured psychotherapy
            - Bulimia nervosa
            - Binge-eating disorder
            - Other specified feeding or eating disorders
        - Prompt medical care visit (eg, primary care) to assess physical health and set weight goal(6)(7)
        - Referral to registered dietitian for dietary planning and nutritional counseling(40)
        - Telehealth services if indicated [T] (41)
    - Discharge Planning as appropriate
    - Patient, family, and caregiver education as appropriate. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, 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] • Monitored meals [W] • Continual observation [X] • Supervision of bathroom use [Y]	• Possible medication	• Exploration of admission precipitants [Z] • Psychiatric, social, medical, dietary, and substance use histories, as well as assessment of food-related or eating-disorder behaviors [AA] [BB] • Mental status and physical examinations [CC] • Laboratory tests [DD] • ECG, if clinically indicated [EE] • Evaluation of fall risk • Symptoms assessed

Day	Clinical Status	Interventions	Medications	Evaluation
				multiple times per shift • Self-efficacy evaluation
2	• Social Determinants of Health Assessment	• **Close observation** • Monitored meals [W] • Supervision of bathroom use [Y]	• Medication review if prescribed	• **Evaluation completed and reviewed** • Weight goal set • Weight [GG] • Symptoms assessed multiple times per shift
3	• **Adherent to dietary plan for at least 24 hours** • **No purging (eg, self-induced vomiting), bingeing, or other problem behaviors (eg, excessive physical activity) for at least 24 hours** • Social Determinants of Health Assessment	• **Close observation at reduced intensity** • Monitored meals [W] • Possible supervision of bathroom use [Y]	• Medication review if prescribed	• Weight [GG] • Transition to patient check-in with staff
4	• Social Determinants of Health Assessment	• **Close observation at reduced intensity** • Dietary plan reviewed and revised as necessary • Possible supervision of bathroom use [Y]	• Medication review if prescribed	• Weight [GG] • Patient check-in only

Day	Clinical Status	Interventions	Medications	Evaluation
5	• **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** • **Weight stable, increasing, or weight issues manageable/treatable at available lower level of care** • **Physical status acceptable** [II] • **Thoughts of suicide or Harm absent or manageable/treatable at available lower level of care** • **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 absent or manageable/treatable at available lower level of care** • Social Determinants of Health Assessment • Complete Discharge planning • Discharge	• **No close observation** • Review follow-up treatment and crisis plan with patient and supports [JJ]	• Medication review if prescribed	• Weight [GG]

(6)(7)(14)(17)(42)(44)(47)(48)(49)(50)(51)(52)

Recovery Milestones are indicated in **bold**.

Goal Length of Stay: 4 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)(49):
    - Persistent self-induced vomiting to purge food and/or continued bingeing or other problem eating behaviors
        - Expect prompt reassessment steps, including:
            - Identification of precipitants of purging, bingeing, or other problem eating behaviors, 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
            - Review of behavioral management plan if applicable [KK]
            - Repeat serum electrolytes
        - Anticipate treatment measures, including as appropriate:
            - Interventions to address psychosocial precipitants of purging, bingeing, or other problem eating behaviors
            - Supervision of bathroom use
            - Initiation or modification of behavioral management plan [KK]
        - Expect brief to moderate stay extension.
    - Current plan for suicide or serious Harm to self(1)(2)(3)(53)
        - Expect prompt reassessment steps, including:
            - Identification of precipitants of thoughts of suicide or self-harm
            - Assessment for comorbid mood disorder
        - Anticipate treatment measures, including as appropriate:
            - Psychosocial interventions to relieve precipitants
            - Appropriate treatment of mood disorder if diagnosed
        - Expect brief to moderate stay extension.
    - Cardiac arrhythmia (eg, supraventricular tachycardia, conduction disorder)(54)
        - Anticipate diagnostic (eg, ECG) and therapeutic (eg, medication) measures.
        - Expect brief to moderate stay extension.
    - Major depressive disorder
        - Anticipate close observation (eg, for suicidality) and treatment measures (eg, pharmacotherapy, psychotherapy).
        - Expect brief to moderate stay extension.
    - Malnutrition (eg, protein-calorie malnutrition, nutritional marasmus)
        - Anticipate refeeding program, nutritional assessments, and careful observation.
        - Expect brief to moderate stay extension.

Hospital Care Planning

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- Evaluation and care needs may include(6)(7)(17):
    - Diagnostic test scheduling and completion, including:
        - Urine drug screening. See Urine Toxicology Testing.
        - Pregnancy test
        - Laboratory tests [DD]
        - ECG [EE]
    - Treatment and procedure scheduling and completion, including:

        - Psychosocial interventions emphasizing admission precipitants and barriers to discharge [FF] (43)
        - Clinical management and psychoeducation [HH]
        - Psychological testing to evaluate cognitive function and personality dynamics [LL]
        - Dietary planning and nutritional counseling(40)
        - Parental component of psychosocial interventions
        - Structured psychotherapy
        - Possible medication
        - Potassium repletion, using oral potassium chloride, for marked hypokalemia
        - Upper gastrointestinal endoscopy
    - 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 [I] (41)
    - Monitoring patient's status for deterioration and comorbid conditions, including:
        - Dental erosion due to self-induced vomiting
        - Gastroesophageal injury due to self-induced vomiting
        - Electrolyte disturbance due to vomiting or misuse of laxatives or diuretics
        - Peripheral edema due to withdrawal from laxatives or diuretics
        - Constipation due to laxative misuse or withdrawal
        - Identification and treatment of psychiatric comorbidity (eg, depression, anxiety disorders)

Discharge

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Discharge Planning

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- Discharge planning includes [MM] :
    - Assessment of needs and planning for care, including(58):
        - 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.(57)
        - 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
            - Medication management, adherence instruction, and side effects assessment(59)(60)
            - Nutrition and hydration management(61)
            - Psychosocial assessment, management, and referrals(61)
    - Early identification of anticipated discharge destination; options include(62)(63):
        - 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(63):
        - Patient and caregiver education complete. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, 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(67)(68):
            - Inpatient care and service providers
            - Primary care provider
            - All post-discharge care and service providers
        - Appointments planned or scheduled, which may include:
            - Primary care provider
            - Behavioral health provider(69)
            - Dietitian(61)
            - Psychiatrist(61)
            - Other
        - Outpatient testing and procedure plans made, which may include:
            - Laboratory testing(70)
            - Other
        - Referrals made for assistance or support, which may include:
            - Alcohol and other drug abuse or dependence treatment(71)
            - Behavioral health services (eg, counseling)(61)
            - Community services
            - Financial, for follow-up care, medication, and transportation
            - Self-help or support groups
            - Tobacco use treatment
            - Other
        - Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:
            - Nutritional supplements
            - Other

Discharge Destination

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Usual

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- Outpatient care. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Outpatient Care.

Alternate

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- Intensive outpatient program. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Intensive Outpatient Program.
- Partial hospital program. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Partial Hospital Program.
- Residential care. See Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders: Residential Care.

See Behavioral Health Levels of Care for further information.

Evidence Summary

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Background

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Bulimia nervosa generally begins in late adolescence or early adulthood and has a variable, often chronic course that may be complicated by psychiatric comorbidities, such as anxiety, depression, substance use, and personality disorders, as well as an increased risk of suicidal ideation.(4)(6)(7)(17)(18)(72)(73) **(EG 2)** Binge-eating disorder differs from bulimia nervosa in that patients do not engage in inappropriate compensatory behaviors to avoid weight gain (eg, self-induced vomiting, misuse of laxatives).(18)(74)(75) **(EG 2)** Other eating disorders include pica and rumination disorder and avoidant/restrictive food intake disorder.(18) **(EG 2)**

Length of Stay

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Analysis of national hospital discharge data shows 28% of hospitalized pediatric patients (younger than 18 years of age) with the principal diagnosis of bulimia nervosa or a related disorder discharged in 4 days or fewer.(49) **(EG 3)**

Treatment

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Psychosocial therapy - Bulimia nervosa: A randomized controlled trial of 130 adolescents with bulimia nervosa found that family-based therapy was superior to cognitive behavioral therapy (CBT) for promoting abstinence from binge eating and purging at the end of treatment and at 6-month follow-up; however, there were not significant differences between the 2 groups at 12-month follow-up.(76) **(EG 1)** A study of 74 adolescents with eating disorders found that short-term (5-day treatment) intensive family therapy participation resulted in either full remission (61%) or partial remission (27%) of eating disorder symptoms over a mean follow-up of 30 months, including binge-purging symptoms.(77) **(EG 2)** A systematic review and meta-analysis of 2 randomized controlled trials (165 patients) of psychotherapy in the treatment of adolescents with bulimia nervosa 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.(78) **(EG 1)** Extrapolating from adult findings, an expert consensus guideline recommends CBT as the treatment of choice, and antidepressant medication as a secondary alternative, for bulimia nervosa in children and adolescents.(17) **(EG 2)**

Psychosocial therapy - Binge-eating disorder: A systematic review and meta-analysis of treatment of binge-eating disorder that addressed trials comparing cognitive behavioral therapy (CBT) and no or limited intervention concluded that there was high-strength evidence to support therapist-led CBT for binge abstinence, binge frequency, and eating-related psychopathology.(75) **(EG 1)** A meta-analysis of treatments for binge-eating disorder (81 heterogeneous randomized controlled trials with 1 study including adolescents) found psychotherapy (CBT was most commonly studied) to have a large effect size in significantly reducing binge-eating episodes.(38) **(EG 1)**

Psychosocial therapy - Other specified eating disorders: For patients diagnosed with a type of eating disorder other than anorexia, bulimia nervosa, or binge-eating disorder, expert consensus guidelines recommend using treatments shown to be effective for the full syndrome disorder that most closely resembles the patient's presentation.(6)(7)(17) **(EG 2)** Reviews of treatments for rumination disorder emphasize the role of behavioral interventions, including training patients in diaphragmatic breathing exercises.(79)(80)(81) **(EG 2)** A systematic review of behavioral treatments for pica in children and adolescents (including 30 case

studies) found evidence to support that least restrictive treatment should be offered first including contingent reinforcement and discrimination training.(82) **(EG 1)** Reviews of the treatment of pica in children with developmental disabilities have suggested that applied behavioral analysis methods have shown the greatest effect in treating this disorder, though a specific applied behavioral analysis procedure or methodology most likely to be effective has not yet been determined.(83)(84) **(EG 2)**

Pharmacotherapy - Bulimia nervosa: When antidepressant treatment is administered without additional specialized eating-disorder program components, dropout rates tend to be high, and therapeutic benefit is minimized.(17)(85) **(EG 2)** An expert consensus guideline recommends cognitive behavioral therapy as the treatment of choice, and antidepressant medication as a secondary alternative for bulimia nervosa in children and adolescents.(17) **(EG 2)** Trials of psychotropic agents in the treatment of bulimia nervosa have found that antidepressants, in particular fluoxetine, are somewhat effective in decreasing urges to binge and purge in adolescent patients, and also may benefit comorbid psychiatric conditions.(14)(39) **(EG 2)**

Pharmacotherapy - Binge-eating disorder: A meta-analysis of treatments for binge-eating disorder (81 randomized controlled trials described as heterogeneous with 1 study including adolescents) found that pharmacotherapy (mainly lisdexamfetamine and second-generation antidepressants) had a positive small effect size in decreasing episodes of binge eating and increasing abstinence from binge eating, though the reviewers rated the quality of evidence as low or very low.(38) **(EG 1)** It is unclear if the benefits reported for the use of antidepressants in the treatment of binge-eating disorder are related to a direct effect on this condition, or are due to amelioration of comorbid mood or anxiety symptoms.(86) **(EG 2)** A systematic review identified 2 randomized placebo-controlled trials of topiramate for treatment of binge-eating disorder and found moderate-strength evidence for improving binge abstinence and weight loss, as well as reducing binge eating, and the obsessions and compulsions related to binge eating. The researchers questioned the ability to generalize their findings to the child/adolescent population but did find data to support loss-of-control eating in early adolescence predicted similar behavior in later adolescence based on low-strength evidence.(75) **(EG 1)**

Pharmacotherapy - Other specified feeding or eating disorders: For patients diagnosed with a type of eating disorder other than anorexia, bulimia nervosa, or binge-eating disorder, expert consensus guidelines recommend using treatments shown to be effective for the full syndrome disorder that most closely resembles the patient's presentation.(6)(7)(17) **(EG 2)** Behavioral therapy is the cornerstone of treatment for rumination syndrome; baclofen and tricyclic antidepressants have been evaluated in small studies and are considered as potential adjunctive therapies; there is little evidence for the use of pharmacologic intervention in the pediatric population.(79)(80)(81)(87) **(EG 2)** There is insufficient evidence to determine if there is any role for pharmacotherapy in the treatment of pica.(83)(84) **(EG 2)**

Level of Care

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Patients with bulimia nervosa or related disorders can nearly always be treated in outpatient settings; however, patients with these conditions occasionally require inpatient care because of malnutrition, physical complications of self-induced vomiting, laxative or diuretic misuse (eg, severe hypokalemia, esophageal injury), inability to curtail dangerous behaviors in lower levels of care, or imminent risk of suicide or serious self-harm.(6)(7)(17) **(EG 2)**

Residential care facilities may provide an effective, less restrictive alternative to inpatient care for patients who need around-the-clock behavioral care to manage severe purging or risk of suicide, but do not require continuous medical or nursing attention.(6)(7)(88) **(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 similarly to the day shift of an inpatient unit.(13) **(EG 2)** A randomized trial of patients with bulimia nervosa comparing inpatient treatment to an 8-hour day clinic program 5 days a week demonstrated similar outcomes between the 2 settings.(89) **(EG 1)** While partial hospital programs occasionally may be indicated for patients with bulimic or bulimic subtype disorders refractory to standard outpatient care, intensive outpatient or outpatient care programs may be equally effective, as the relatively short periods of meal supervision and observation provided in partial hospital programs generally are

inadequate to address purging behaviors.(6)(7)(17) **(EG 2)** Intensive outpatient programs typically provide 3 to 4 hours of psychosocial treatment, 1 to 4 days a week (usually 6 to 12 hours of treatment per week), mostly by using a group format, and are intended for circumstances when a patient needs a type or frequency of treatment that is not available in a standard outpatient setting.(13) **(EG 2)** An intensive outpatient program may be appropriate for a patient with bulimia nervosa if it can provide a therapy such as cognitive behavioral therapy with demonstrated efficacy for bulimia nervosa, when that therapy is not available in a standard outpatient setting.(17) **(EG 2)** A retrospective study including admission and discharge data from 773 patients (age 11 to 68 years with over half diagnosed with other specified feeding and eating disorder) admitted to partial hospital and intensive outpatient levels of care found that 54.9% of patients showed statistically significant improvements in eating disorder severity by discharge.(90) **(EG 2)**

Remission and Relapse

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Most studies of the use of antidepressant medications to treat bulimia have not reported follow-up remission rates, but the evidence suggests that less than 25% of patients achieve lasting remission. Patients who receive fluoxetine during acute treatment and experience a significant reduction in vomiting may have lower relapse rates in the following year if the medication is continued.(17)(85) **(EG 2)** A meta-analysis of psychological or behavioral treatments for binge-eating disorder (including 39 randomized controlled trials with 65 treatment conditions (mostly CBT)) found that 45.1% of patients achieved abstinence from binge eating at the post-treatment visit, and 42.3% showed abstinence from binge eating at the most recent follow-up visit.(91) **(EG 1)** A randomized controlled trial of CBT and psychodynamic therapy in the treatment of bulimia nervosa in female adolescents (81 participants) found both treatments to be effective in promoting recovery, with remission rates of 33% and 31%, respectively.(92) **(EG 1)**

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.

11/6/2023 - Upgraded to 27th edition MCG with BMI removed from clinical indications.

References

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

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Footnotes

Return to top of *RMHP Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Child or Adolescent: Inpatient Care - BHG*

[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).(41) [T in Context Link 1, 2]

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

[V] A registered dietitian should develop a dietary plan, taking into consideration the patient's healthy weight goal and caloric and nutrient needs.(6)(7)(40) [V in Context Link 1]

[W] 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.(6)(7) [W in Context Link 1, 2, 3]

[X] 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) [X in Context Link 1]

[Y] 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) [Y in Context Link 1, 2, 3, 4]

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

[AA] Medical history should include documentation of last menstrual period.(42) [AA in Context Link 1]

[BB] 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)(42) When available, outside observations (eg, by family members) should be included in the assessment.(42) [BB in Context Link 1]

[CC] History and examination should include determination of BMI as well as date of last menstrual period.(42) [CC in Context Link 1]

[DD] 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.(42) [DD in Context Link 1, 2]

[EE] Examples of possible indications for ECG include electrolyte abnormalities or hypotension.(42) [EE in Context Link 1, 2]

[FF] Psychosocial interventions should be individualized, address all admission precipitants and barriers to discharge, and involve family and other supports as necessary.(33)(43)(44) [FF in Context Link 1, 2, 3, 4, 5]

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

[HH] Clinical management should include discussion of the psychological and physical consequences of attempting to normalize diet and eating patterns and the beneficial and adverse effects of any medication that is prescribed.(6)(7)(17) [HH in Context Link 1, 2]

[II] 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.(6)(7)(17) [II in Context Link 1]

[JJ] 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.(45)(46) [JJ in Context Link 1]

[KK] A behavioral management plan uses positive reinforcements (eg, privileges) and negative reinforcements (eg, monitored use of bathroom) to encourage restraint from purging.(6)(7) [KK in Context Link 1, 2]

[LL] Routine assessment upon admission is not indicated. Testing that would not affect or contribute substantially to a diagnosis or treatment plan is inappropriate.(55)(56) [LL in Context Link 1]

[MM] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(57) [MM in Context Link 1]

Codes

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ICD-10 Diagnosis: F50.2, F50.81, F50.82, F50.89, F50.9, F98.29, F98.3, R63.4, R63.6

DSM-5: F50.2, F50.81, F50.82, F50.89, F50.9, F98.3