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RMHP Eating Disorders, Inpatient Behavioral Health Level of Care, Child or Adolescent

MCG Health
Behavioral Health Guidelines
27th Edition

ORG_OTG: RMHP-B-913-IP-27 (BHG)

Admission Guidelines

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

- 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)

Recovery Course

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Stage	Clinical Status	Interventions	Evaluati
1	• **Clinical Indications met** [T] • **Treatment plan with goals and progress measurement in place** • **Nutritional plan with measurable goals in place** • Social Determinants of Health Assessment • Begin Discharge planning	• **Appropriate crisis management instituted or documented as not needed** • **Medical treatment of physiologic abnormalities or injury ongoing or not needed** • **Begin Care coordination** • **Close observation or regular checks done for meals, bathroom use, and safety** • **Appropriate treatment plan review**	• **Evaluatio and revie** • **Nutritiona complete** • **Symptom functionir at approp documen** • **Physician patient ar appropria (eg, daily** • **Review o medicatic adjustme appropria documen**
2	• **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** • **Patient able to function and participate at next level of care** • **Weight status acceptable** • **Risk status acceptable** • **Treatment goals for level of care met** • Social Determinants of Health Assessment • Complete Discharge planning • Discharge	• **Medical needs absent or manageable/treatable at available lower level of care**	

Stage	Clinical Status	Interventions	Evaluati
(1)(2)(3)(4)(6)(7)(14)(17)(27)(32)(38)(39)(40)(41)(42)(43)(44)			

Recovery Milestones are indicated in **bold**.

Care Planning and Evaluation

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- Planning and evaluating appropriate care should address(6)(7)(14)(17)(31)(45):
  - Evaluation and care needs, which may include(6)(7)(14)(17):
    - Treatments and procedures, including(4)(45)(46):
      - Psychosocial interventions emphasizing admission precipitants and barriers to discharge
      - Clinical management and psychoeducation
      - Psychological testing
      - Possible adjunctive medication
      - Dietary planning and nutritional counseling(47)
      - Parental component of psychosocial interventions
      - Structured family therapy(48)(49)
      - NG feeding or parenteral nutrition
      - Physical monitoring (eg, primary care)
    - Consultation, assessment, and other services, including:
      - Substance use disorder assessment
      - Conference with school
      - Self-help or support group referral
      - Social services consultation for placement or housing
      - Telehealth services if indicated [U] (50)

Discharge Guidelines

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- Continued inpatient care generally is needed until **1 or more** of the following(6)(7)(14)(17)(21):
  - Inpatient care is no longer necessary due to adequate patient stabilization or improvement, as indicated by **ALL** of the following:
    - 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, as indicated by **ALL** of the following:
      - Purging (eg, self-induced vomiting), bingeing, and other problem behavior (eg, excessive exercise) absent or manageable/treatable
      - Patient able to function and participate at available lower level of care
    - Patient able to function and participate at next level of care
    - Weight status acceptable, as indicated by **1 or more** of the following(6)(7):
      - Weight is increasing at rate of at least 1 lb (0.5 kg) per week in residential setting.
      - Weight is increasing at rate of at least 2 lb (0.9 kg) per week in hospital setting.
      - Weight is stable, and reason for admission was not absence of recent weight gain.
    - Risk status acceptable, as indicated by **ALL** of the following(1)(2)(8)(11)(35):
      - Danger to self or others manageable/treatable, as indicated by **1 or more** of the following:

- Absence of Thoughts of suicide, homicide, or serious Harm to self or to another
- Thoughts of suicide, homicide, or serious Harm to self or to another present but manageable/treatable at available lower level of care

- Patient and supports understand follow-up treatment and crisis plan.
- Provider and supports are sufficiently available at lower level of care.
- Patient, as appropriate, can participate as needed in monitoring at available lower level of care.

- Medical needs absent or manageable/treatable at available lower level of care, as indicated by **ALL** of the following(1)(2)(8)(11)(35):
  - Adverse medication effects absent or manageable/treatable
  - Medical comorbidity absent or manageable/treatable
  - Medical complications absent or manageable/treatable (eg, complications of eating disorder)
  - Substance-related disorder absent or manageable/treatable
- Treatment goals for level of care met

- Inpatient care is no longer appropriate as patient or guardian no longer consents to treatment and involuntary treatment is not deemed necessary.

Discharge Planning

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- Discharge planning needs may include(6)(7)(14)(17):
  - Rapid decision and planning regarding next level of care; considerations include:
    - Plan for monitoring meals, if necessary
    - Plan for monitoring for dangerous ideation or behavior, if necessary(51)
  - Aftercare plan development with input from multiple providers, patient, and patient's supports
  - Preparation of patient and supports for transition to next level of care, including:
    - Ensure sufficient knowledge of:
      - Patient's illness
      - Dietary plan
      - Warning signs of relapse or illness exacerbation
      - Treatment resources
      - Community supports
    - Assess ability to attend school and participate in usual activities.
    - Review crisis plan with patient and supports.(40)(52)
  - Follow-up appointments, including:
    - Structured family therapy(48)(49)
    - Pharmacotherapy and clinical management(53)
    - Psychiatrist for psychiatric comorbidity(54)
    - Medical care visit (eg, primary care) for medical comorbidity(54)
    - Registered dietitian
  - Referrals for community assistance and support, including:
    - Self-help or support groups for patient, family, and caregivers
    - Community services for housing, financial, food, or transportation needs
  - Medications and supplies, including:
    - Psychotropic medications
    - Medications for comorbid medical conditions
    - Vitamin and mineral supplements(55)
    - Liquid feeding supplements

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.

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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] See Admission Guidelines in this guideline. [T in Context Link 1]

[U] 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).(50) [U in Context Link 1]
