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Updated 12/5/23

Eating Disorder Algorithm — Provider Decision Support

Inclusion Criteria

- Concern for eating disorder (ED): anorexia nervosa, avoidant restrictive food intake disorder, eating disorder unspecified, bulimia nervosa of any degree of severity.

Exclusion Criteria

- Other diagnosis resulting in severe malnutrition that is NOT an eating disorder (e.g. cystic fibrosis, IBD).

Does your patient have...

- Unexplained weight loss or weight gain
- BMI <18 (adults)
- Unexplained GI symptoms
- Unexplained abdominal pain
- Electrolyte imbalances
- Significant changes in growth chart trend (pediatrics)
- Or any other complications included in the Quick Guide to Medical Complications of EDs

If **YES** to **ANY** of the above questions… **Eating disorder is suspected.**

- Administer SCOFF & DSM-5 if appropriate (UpToDate see Pg 2)
- Orthostatic assessment
- Determine appropriate level of care (see below and Pg 3-4)

If **NO** to ALL of the questions… ED is NOT suspected.

Consider **inpatient** if meets **ANY** of the following criteria:

- HR <40
- Weight <75th%ile of median BMI
- Severe dehydration
- Acute food refusal
- EKG changes
  Ex: prolonged QTc males>450ms/ females>470ms or severe bradycardia, other arrhythmias, etc.
- Intractable vomiting
- Severe electrolyte imbalance
  Ex: hypokalemia, hyponatremia, hypophosphatemia
- Orthostatic hypotension
- Precipitous weight loss
- Hypoglycemia
- Hypothermia
- Comorbid psych or medical conditions that prohibits or limits appropriate outpatient treatment
  Ex: extreme suicidality, acute food refusal, etc.
- **For PEDS**: Call the on call pediatric hospitalist to discuss if pt meets the pediatric criteria
- **For Adults**: Notify ED of acuity

Initiating **outpatient** care:

- Enter nutrition referral for nutrition history and assessment (REF50)
- Enter behavioral health referral (REF8)
- Initial labs
  Include: CBC, electrolytes (Na, Mg, P, K, Glucose), LFT, UA, TSH, baseline EKG
- View Academy for Eating Disorders (AED) report for additional guidelines and recs (AED Guide)

Follow Up Outpatient Care:

- Establish plan for follow-up care including…
  monthly check in with PCP, blind weight assessment, HT, labs, BP, temp, orthostatic changes
- Follow up with pediatric pts weekly or biweekly for precipitous wt drop or near criteria for inpatient
- Increase follow-ups with adult pts to weekly as needed. Examples of possible indications below.
  Ex: Decrease in PO intake for >5 days, increase in disordered behaviors, pt accountability, etc.
- Consider SSRI like fluoxetine for binge/purge of bulimia, or if anorexic with weight > 85th%ile to decrease rate of relapse (not good evidence for use of other medications)
- Consider higher level of outpatient if not making progress, consult case management
- Reconsider inpatient referral if any of the inpatient criteria arise during follow up care

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SCOFF Questionnaire

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

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

O – Have you recently lost more than **O**ne stone (6.35 kg) in a three-month period?

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

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

Document results in EPIC. An answer of 'yes' to two or more questions warrants further questioning and more comprehensive assessment.

Administer DSM-5 for suspected eating disorder and document results sin EPIC. (UpToDate)

See American Psych Association Level of Care Guidelines for further information on what support your patient may need. (see pages 3 and 4)

American Psychiatric Association Level of Care Guidelines for Patients with Eating Disorders					
	Level 1: Outpatient	**Level 2: Intensive Outpatient**	**Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]**	**Level 4: Residential Treatment Center**	**Level 5: Inpatient Hospitalization**
Medical status	Medically stable to the extent that more extensive medical monitoring, as defined in levels 4 and 5, is not required			Medically stable to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed	*For adults: Heart rate <40 bpm; blood pressure <90/60 mmHg; glucose < 60 mg/dl; potassium < 3 mEq/L; electrolyte imbalance; temperature < 97.0°F; dehydration; hepatic, renal, or cardiovascular organ compromise requiring acute treatment; poorly controlled diabetes* *For children and adolescents: Heart rate near 40 bpm, orthostatic blood pressure changes (> 20 bpm increase in heart rate or >10 mmHg to 20 mmHg drop), blood pressure <80/50 mmHg, hypokalmia,[b] hypophosphatemia, or hypomagnesemia*
Suicidality[c]	If suicidality is present, inpatient monitoring and treatment may be needed depending on the estimated level of risk				Specific plan with high lethality or intent; admission may also be indicated in patient with suicidal ideas or after a suicide attempt or aborted attempt, depending on the presence or absence of other factors modulating suicide risk
Weight as percentage of healthy body weight[d]	Generally >85%	Generally >80%	Generally >80%	Generally <85%	Generally <85%; acute weight decline with food refusal even if not <85% of healthy body weight
Motivation to recover, including cooperativeness, insight, and ability to control obsessive thoughts	Fair-to-good motivation	Fair motivation	Partial motivation; cooperative; patient preoccupied with intrusive, repetitive thoughts[e] >3 hours/day	Poor-to-fair motivation; patient preoccupied with intrusive repetitive thoughts[e] 4–6 hours a day; patient cooperative with highly structured treatment	Very poor to poor motivation; patient preoccupied with intrusive repetitive thoughts[e]; patient uncooperative with treatment or cooperative only in highly structured environment

	Level 1: Outpatient	**Level 2: Intensive Outpatient**	**Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]**	**Level 4: Residential Treatment Center**	**Level 5: Inpatient Hospitalization**
Co-occurring disorders (substance use, depression, anxiety)	Presence of comorbid condition may influence choice of level of care				Any existing psychiatric disorder that would require hospitalization
Structure needed for eating/ gaining weight	Self-sufficient	Self-sufficient	Needs some structure to gain weight	Needs supervision at all meals or will restrict eating	Needs supervision during and after all meals or nasogastric/special feeding modality
Ability to control compulsive exercising	Can manage compulsive exercising through self-control	Some degree of external structure beyond self-control required to prevent patient from compulsive exercising; rarely a sole indication for increasing the level of care			
Purging behavior (laxatives and diuretics)	Can greatly reduce incidents of purging in an unstructured setting; no significant medical complications, such as electrocardiographic or other abnormalities, suggesting the need for hospitalization			Can ask for and use support from others or use cognitive and behavioral skills to inhibit purging	Needs supervision during and after all meals and in bathrooms; unable to control multiple daily episodes of purging that are severe, persistent, and disabling, despite appropriate trials of outpatient care, even if routine laboratory test results reveal no obvious metabolic abnormalities
Environmental stress	Others able to provide adequate emotional and practical support and structure	Others able to provide at least limited support and structure	Severe family conflict or problems or absence of family so patient is unable to receive structured treatment in home; patient lives alone without adequate support system		
Geographic availability of treatment program	Patient lives near treatment setting			Treatment program is too distant for patient to participate from home	