Eating Disorders : Nutrition Screening and Level of Care Assessment for Patients - Adult/Pediatric - Ambulatory Clinical Practice Guideline

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Executive Summary

Guideline Overview

The 2006 American Psychiatric Association (APA) Guideline[1] served as the primary outline for this document. This guideline provides indications and recommendations for levels of care for patients diagnosed with an eating disorder.

Key Practice Recommendations

The present Clinical Practice Guideline (CPG) provides recommendations to standardize the screening and scheduling of patients with an eating disorder with a UW Health Registered Dietitian Nutritionist (RDN) in the ambulatory setting.
The key recommendations include:

1. A qualified UW Health RDN should complete the Ambulatory Eating Disorder Screening Assessment with all prospective patients with an eating disorder to determine the appropriate level of care. *(UW Health Class IIa, LOE C)*

2. All patients with an eating disorder who are scheduled with a UW Health RDN should *(UW Health Class IIa, LOE C)*:
   - Have a UW Health referring provider who places the consult for nutrition services and agrees to manage the patient's medical needs in the ambulatory setting with regular communication to the multidisciplinary team.
   - Have concurrent appointments with a licensed therapist, psychologist, or social worker, or be in the process of establishing care (e.g. the patient has an upcoming appointment with a mental healthcare provider).
   - If the patient is currently refusing mental health care, the patient will not be refused initial treatment in the ambulatory setting.

3. In order to continue to receive care in the ambulatory setting, all patients with an eating disorder should *(UW Health Class IIa, LOE C)*:
   - Agree to regular weight checks as determined by the referring provider and/or RDN.
   - Agree to continue appointments with mental healthcare provider(s).
   - Demonstrate progress toward goals mutually set by the RDN, referring and/or primary care physician, patient, and other members of the patient's healthcare team.
   - Meet criteria for ambulatory care (Table 2) and be deemed medically stable by referring provider.

Companion Documents

1. Nutrition Scheduling Algorithm
2. UW Health Eating Disorders – Pediatric – Inpatient Clinical Practice Guideline
3. UW Hospital and Clinics' Lab Test Directory

Pertinent UW Health Policies & Procedures

1. UWMF Policy – MF Person at Risk for Suicide
2. UWHC Policy 10.10 – Suicide Assessment and Prevention
3. UWHC Policy 8.14 – Suicide Assessment and Intervention in Clinic
4. UWHC Policy 10.22 – Admission & Discharge of Patients To & From the Inpatient Psychiatric Unit

Patient Resources

Internal-

1. HFFY #168 – Healthy Eating/Wellness: Your Eating Plan
2. HFFY #264 – Healthy Eating/Wellness: Balanced Food Plan (Rule of Threes)

External-

1. National Institutes of Mental Health. http://www.nimh.nih.gov/health/publications/eating-disorders/index.shtml
2. Eating Disorder Foundation.
3. http://www.eatingdisorderfoundation.org/GettingHelpforPatient.htm
4. Eating Disorder Resource Center. http://www.edrcsv.org/
5. National Eating Disorders Association (NEDA). http://www.nationaleatingdisorders.org/index-handouts
6. National Alliance of Mental disorders. http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/By_Illness/Eating_Disorders.htm
7. ECRI Institute. Bulimia Nervosa Resource Guide. www.Bulimiaguide.org
8. Family-based Treatment of Adolescent Anorexia Nervosa: The Maudsley Approach. http://www.maudsleyparents.org/
9. Brown H. Brave Girl Eating: A family's struggle with Anorexia. HarperCollins Publishers, 2010.
10. Schaefer J & Rutledge T. Life Without Ed: How one woman declared independence. McGraw-Hill Education, 2004, 2014.
11. Herrin M & Matsumoto N. The Parent's Guide to Eating Disorders: Supporting Self-Esteem, Healthy Eating, and Positive Body Image at Home. 2nd Edition. Gurze Books, 2007.
12. Sacker IM & Zimmer MA. Dying to Be Thin. Warner Books, Inc. 1987.
13. Mendelsohn S. It's Not About the Weight; Attacking eating disorders from the inside out. iUniverse Books, 2007.
14. Berg F. Afraid to Eat: Children and Teens in Weight Crisis. 3rd Edition. Healthy Weight Network, 2001.
15. Walsh T & Cameron VL. If Your Adolescent Has an Eating Disorder: An Essential Resource for Parents (Adolescent Mental Health Initiative). Oxford University Press, Inc. 2005.
16. Cash T. The Body Image Workbook: An Eight-step Program for Learning to like your Looks. New Harbinger Publications, 1997.
17. Cohn L & Hall L. Bulimia, A Guide to Recovery. Gurze Books, 2011.

External Resources

For the Healthcare Professional-

1. Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Eating. Disorders. J Am Diet Assoc. 2011;111:1236-1241.
2. Practice Paper of the American Dietetic Association: Nutrition Intervention in the Treatment of Eating Disorders.
3. American Dietetic Association. Standards of practice and standards of professional performance for registered dietitians in disordered eating and eating disorders. J Am Diet Assoc. 2011;111:1242-1249.
4. Academy of Eating Disorders. http://aedweb.org/web/index.php

5. Mehler, P & Andersen A. *Eating Disorders: A Guide to Medical Care and Complications*. Second edition. John Hopkins Press, 2010.
6. Herrin M & Larkin M. Nutrition Counseling in the Treatment of Eating Disorders. Routledge Press, 2012.
7. Reiff, Dan and Kathleen Kim Lampson Reiff. Eating Disorders: Nutrition Therapy in the Recovery Process. Aspen Publishing, 1997.
8. American Dietetic Association and SCAN DPG. Pocket Guide to Eating Disorders.

Scope

Disease/Condition(s): Eating Disorders, which include but are not limited to:

- Anorexia Nervosa,
- Avoidant/Restrictive Food Intake Disorder,
- Bulimia Nervosa,
- Binge Eating Disorder, and
- Other Specified Feeding and Eating Disorder (OSFED). [2-3]

Clinical Specialty: Clinical Nutrition Services, Health Education

Intended Users: Registered Dietitian Nutritionists (RDN) (also known as Registered Dietitian, RD) and Clinical Nutritionists (MS, RDN) within UWHC Department of Clinical Nutrition Services and UWMF Department of Health Education, Nutrition Schedulers, Internal Medicine, Family Medicine, Pediatrics, Psychology, Social Work, and Psychiatry Physicians.

CPG objective(s): To provide evidence-based recommendations and guide practice in determining which patients diagnosed with an eating disorder may be appropriately managed and cared for by a UW Health RDN in the ambulatory setting.

Target Population:

- Any adult or pediatric patient (8 years or older) diagnosed with an eating disorder requiring medical nutrition therapy (MNT) at UW Health ambulatory clinics who has a UW Health primary care physician or UW Health referring provider.
- Any adult or pediatric (8 years or older) patient diagnosed with an eating disorder requiring MNT who does not have a UW Health primary care physician or a UW physician managing their eating disorder care and who does not have access to an RDN trained in MNT for eating disorders in their medical home.

Major Outcomes Considered:

Primary outcomes:

- Ensures that patients with eating disorders seen in nutrition ambulatory clinics are appropriate for that level of care (level 1) and
- Directs patients with an eating disorder that requires a higher level of care on to more intensive programs (inpatient, residential) in interest of patient safety and optimal patient care.

Secondary outcomes:

- Rate of return to goal weight and maintenance of goal weight depending on disease state. [1,5-7]
- Return of menses for female patients[1]
- Reduction in the frequency or severity of eating disorder behaviors[1]
- Improved dietary composition[7-8]

Guideline Metrics:

1. Proportion of patients managed within the correct setting[1,9]:
    a. Level 1 – Ambulatory
    b. Level 2 – Partial Hospitalization or Day Program
    c. Level 3 – Inpatient or Residential
2. Proportion of patients called back by the RDN for screening.
3. Timing between patient call and RDN follow-up for screening.
4. Proportion of attended clinic visits following screening.

Methodology

Methods Used to Collect/Select the Evidence: The workgroup reviewed previously published external guidelines, and conducted electronic searches using PubMed and other databases.

Methods Used to Formulate the Recommendations: The workgroup adopted recommendations developed by external organizations and/or arrived at a consensus through discussion of the literature evidence and expert experiences.

Methods Used to Assess the Quality and Strength of the Evidence/ Recommendations: The workgroup used two rating schemes based upon the sources of each recommendation. The modified Grading of Recommendations, Assessment, Development and Evaluation (GRADE) rating scheme developed by the American Heart Association (AHA) and American College of Cardiology (ACC) was used to assess the quality and strength of the evidence and recommendations not indicated by the American Psychiatric Association (APA).[1]

Rating Scheme for the Strength of the Evidence/Recommendations: See Appendix A for each grading scheme.

Definitions

The following definitions are verbatim from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5):

Anorexia Nervosa is defined as[2-3]:

- Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.

- Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low weight).
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Bulimia Nervosa is defined as [2]:

- Recurrent episodes of binge eating characterized by BOTH of the following:

1. Eating in a discrete amount of time (within a 2 hour period) large amounts of food.
2. Sense of lack of control over eating during an episode.

- Recurrent inappropriate compensatory behavior in order to prevent weight gain (purging).
- The binge eating and compensatory behaviors both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Binge eating disorder is defined as[2]:

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    A. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
    B. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- The binge-eating episodes are associated with three (or more) of the following:
    A. Eating much more rapidly than normal.
    B. Eating until feeling uncomfortably full.
    C. Eating large amounts of food when not feeling physically hungry.
    D. Eating alone because of feeling embarrassed by how much one is eating.
    E. Feeling disgusted with oneself, depressed, or very guilty afterward.
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for 3 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Avoidant/Restrictive Food Intake Disorder is defined as[2]:

- An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
    A. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
    B. Significant nutritional deficiency.
    C. Dependence on enteral feeding or oral nutritional supplements.

D. Marked interference with psychosocial functioning.

- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Other Specified Feeding and Eating Disorder is defined as[2]:

- Presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.
- The other specified feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder. This is done by recording "other specified feeding or eating disorder" followed by the specific reason (e.g., "bulimia nervosa of low frequency").
- Examples of presentations that can be specified using the "other specified" designation include the following:
  A. **Atypical anorexia nervosa:** All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
  B. **Bulimia nervosa (of low frequency and/or limited duration):** All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
  C. **Binge-eating disorder (of low frequency and/or limited duration):** All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.
  D. **Purging disorder:** Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
  E. **Night eating syndrome:** Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another

mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

Introduction

Eating disorders are complex illnesses that affect both pediatric and adult populations with increasing frequency. Pediatric and adult patients have unique features related to developmental processes, environmental and family stressors, life experiences and comorbid conditions that are critical considerations in determining the diagnosis, treatment, and outcome of eating disorders. Patients experiencing serious medical compromise often require hospitalization.[1,4] The present CPG is focused on providing recommendations for choosing the appropriate treatment setting for patients with an eating disorder.

Recommendations

Screening and Assessment

Patients with an eating disorder may be treated across inpatient, outpatient, or residential settings and it is important to determine the appropriate setting in order to maximize the benefits of treatment. Pretreatment evaluation of patients with an eating disorder diagnosis is essential in choosing the appropriate treatment setting.[1,4] *(APA Grade I)*

Any patient who meets the following criteria should complete the Ambulatory Eating Disorder Screening Assessment (See Appendix B): *(UW Health Class IIa, LOE C)*

- Have a referral and coexisting medical care from a UW Health referring medical provider.
- Have concurrent appointments with a licensed therapist, psychologist, or social worker, or beginning the process of establishing care (e.g. the patient has an upcoming appointment with a mental healthcare provider.)
- Agree to regular weight checks as determined by the referring provider and /or RDN

UW Health Ambulatory Eating Disorder Screening Assessment
1. Is the patient under the care of a UW-Health physician or does the patient have a UW-Health Primary Care Provider (PCP)?
2. Is the patient actively working with or pursuing care with a mental healthcare provider?
3. Does the patient meet the weight guideline appropriate for Level 1 care?

The patient's referring provider, or PCP, should agree to manage the patient's medical needs in the ambulatory setting. Therefore, patients whom answer "yes" to all three questions of the Screening Assessment may be eligible for management within the ambulatory setting.

Determining Level of Care

It is important to consider the patient's overall physical condition, psychological status, degree and control over eating disorder behaviors, level of functioning, and social circumstances rather than relying on one or more physical parameters (such as weight) when determining a patient's initial level of care.[1,4] *(APA Grade I)*

The patient's weight is, however, a key variable in determining the appropriate level of care. Weight classifications differ for pediatric (8 to 18 years) and adult (> 18 years) patients. The weight assessment can pose a challenge because normal weight ranges are individualized; a variety of weight thresholds related to underweight status have been published.[10] Body mass index (BMI) is a useful tool due to its simplicity; however there are several limitations to utilizing this measure alone. Therefore, it is recommended that the clinician take a global approach and consider the best weight assessment for the individual, as well as, the individual's body frame, weight history, growth trajectory, and parental weight, height and growth trends.

Calculation of Ideal Body Weight (IBW) via Hamwi method for adult patients (>18 years) [11]

The following steps should be taken in order to calculate IBW based on inches (in) and pounds (lbs.).

For Males:

1. Identify the patient's height (inches, in).
2. For the first 60 inches, or 5 feet, establish 106lbs for the IBW.
3. Add 6lbs to 106lbs for every inch greater than 5 feet.

EXAMPLE: Male patient who is 66 inches tall would have an IBW of 142lbs.

For Females:

1. Identify the patient's height (inches, in).
2. For the first 60 inches, or 5 feet, establish 100lbs for the IBW.
3. Add 5lbs to 100bs for every inch greater than 5 feet.

EXAMPLE: Female patient who is 64 inches tall would have an IBW of 120lbs.

Calculation of the Body Mass Index (BMI)

The following steps should be taken in order to identify the BMI.

1. Identify the patient's height (centimeters, cm) and weight (kilograms, kg).
2. Calculate the patient's body mass index (BMI) via the following equation:
   $BMI = Weight / (Height)^2$

Note the following expanded underweight classifications for BMI[2]:

- Mild: BMI 17.0-18.5
- Moderate: BMI 16.0-16.99
- Severe/Extreme: BMI $\leq$ 15.99

Calculation of Expected Body Weight (EBW) via the BMI method for pediatric patients (8 to 18 years) [12-15]

The following steps should be taken in order to identify the EBW.

1. Identify the patient's height (centimeters, cm) and weight (kilograms, kg).
2. Calculate the patient's body mass index (BMI) via the following equation:
   BMI = Weight / (Height) ^{2}
3. Identify the median (50th percentile) BMI for the patient using the appropriate CDC's BMI-for-Age growth chart by gender and age.
4. Compare the patient's calculated BMI to the median BMI on the CDC's growth charts via the following equation:
   %EBW = BMI / 50th percentile BMI-for-age and height × 100
5. A BMI at the 50th percentile would be the expected median or the EBW.

Currently, the literature defines three levels of care for the treatment of an eating disorder.[1, 9]

- **Level 1 – Ambulatory**
  - Treatment and management of patients within the primary care setting via a multidisciplinary team, which may or may not be housed in the same location. Treatment includes regular visits with all team members, which may include a primary care physician, registered dietitian nutritionist, nurse, social worker, and licensed therapist.

- **Level 2 – Partial Hospitalization or Day Program**
  - An intermediate level of care for patients who require more than ambulatory care but less than 24-hour hospitalization. These programs prevent the need for hospitalization and function as a "step- down" from inpatient to ambulatory care.

- **Level 3 – Inpatient or Residential**
  - The greatest level of care that provides 24-hour surveillance and treatment with a multidisciplinary team. Hospital-based treatment is less common with suitable level 1 and 2 treatment programs.

Table 1: Medical Indications for Inpatient Treatment (Level 3)

Medical Indications for Inpatient Treatment	
See UW Health Eating Disorders – Pediatric – Inpatient Guideline	
Weight[2]	< 75% IBW (Approximate BMI ≤ 15.99 in adults) Rapid Weight Loss (i.e., > 10 lbs. in 2 wks.)
Temperature	Hypothermia (< 97.0°F or 36.1°C)
Cardiovascular	Heart rate < 50 beats per minute (daytime) or < 40 beats per minute (nighttime) Decrease in systolic blood pressure of 20 mmHg OR decrease in diastolic blood pressure of 10 mmHg OR increase in heart rate > 20 beats per minute. Arrhythmia
Abnormal Lab Values[16]	Clinically significant abnormal lab values for the following: Electrolytes: • Sodium • Potassium • Chloride • Magnesium • Calcium • Phosphorus Malnutrition indicators: • Blood Urea Nitrogen • Creatinine • Glucose • Albumin • Thyroid Stimulating Hormone Anemia evaluation (Complete Blood Count, CBC): • Red Blood Cell count • Hemoglobin • Hematocrit For Females only: • Follicle-stimulating Hormone • Luteinizing Hormone • Prolactin
Additional Symptoms	Chest pain Syncope Acute food refusal
Failure of ambulatory/outpatient therapy	

The ambulatory RDN should confirm that the patient is at Level 1 (see Table 2) for all required level of care variables as described by the APA[1,4]

- Medical status;
- Suicidality;
- Weight, as the percentage of healthy body weight (IBW) or body mass index (BMI);
- Motivation to recover;
- Co-occurring physical and mental disorders;
- Structure needed for eating/gaining weight;
- Ability to control compulsive behaviors, including exercising, purging, and binging;
- Psychosocial and environmental problems; and
- Geographic availability of treatment program.

There are three exceptions to the aforementioned definition.

- If the prospective patient is 80-85% of his or her ideal body weight (IBW), or has an approximate body mass index (BMI) of 16.0 to 16.99, and all other variables are within Level 1 criteria, the RDN may offer the patient up to three ambulatory visits over a 6-week period to establish healthy eating habits and weight gain to reach ≥85% IBW, or approximate BMI of ≥ 17.0. *(UW Health Class IIa, LOE C)*
- If the prospective patient is ≥ 85% IBW (approximate BMI of ≥ 17.0) and two or more other variables are at Level 2 or greater, the RDN may use his or her clinical judgment to either continue visits, or may decline care in the ambulatory setting and work with the patient's referring medical provider to refer the patient to other programs and resources for more intensive eating disorder treatment. *(UW Health Class IIa, LOE C)*
- In the pediatric adolescent population, the RDN may consult with patients beyond Level 1 (**Table 2**) provided the oversight of a medical provider in the eating disorder specialty and both the RDN and medical provider concur on expert opinion.

Table 2. Key characteristics of patients with eating disorders, by level of care [1,9]

Variable	Level 1: Outpatient	Level 2: Partial Hospitalization	Level 3: Inpatient or Residential
Medical status	Stable. Extensive medical monitoring not required	Stable. IV, NG tube, daily labs not needed	Clinically significant abnormalities outlined in Table 1.
Weight [a, b]	Adult Patient [c]: ≥ 85% IBW [a] (Approximate BMI 17-18.5) [b]	Adult patient [c]: 80-85% IBW [a] (Approximate BMI 16.0-16.99) [b]	Adult patient [c]: < 75% IBW [a] (Approximate BMI ≤ 15.99) [b]
	Pediatric Patient [c-e]: Greater than the 3rd percentile for BMI-for-age and/or following established personal growth curve.	Pediatric Patient [c-e]: • Less than the 3rd percentile for BMI-for-age, • Dropped 2 curves from previously established BMI-for-Age curve, or • Delayed or stopped growth after previously established growth curve.	
Motivation [f]	Fair to good motivation to recover. Actively participates in sessions and makes effort to follow nutrition plan.	Decreased or partial motivation to recover, cooperative	Refusal. Eating <1000 kcal/day for extended time. Requiring enteral nutrition.
Comorbid disorders [f, g]	All comorbid disorders are stable and not disrupting daily life.	Presence of comorbid disorders may influence choice of level of care	
Structure required for weight maintenance	Self-sufficient. Follows meal plan with rare engagement of eating disorder behaviors.	Needs some structure to gain weight.	Needs close supervision to ensure calorie intake and guard against ED behaviors (purge, laxatives, etc.), may be uncooperative
Purging Behavior	Rare or can greatly reduce incidents in unstructured setting.	Needs help to inhibit purging or struggles to stop.	Needs supervision during and after all meals.
Ability to control exercise	Includes ≤ 30-60 minutes of exercise per day. Openly discusses and sets goals with RDN.	Some degree of outside structure beyond self-control is needed to prevent compulsive exercise.	
Social Support [f]	Social support needs met.	Decreased social support.	Limited support from others Severe family or social problems.

a. Ideal body weight (IBW) is calculated using: Hamwi Formula for Men (106 lbs for first 5 feet + 6 lbs for each inch over 5 feet) and Hamwi Formula for Women (100 lbs for first 5 feet + 5 lbs for each inch over 5 feet). [11]
b. BMI is calculated via via the following equation: BMI = Weight / (Height) [2]. The patient's current height (centimeters, cm) and weight (kilograms, kg) are required. Note the following expanded underweight classifications for BMI: Mild: BMI 17.0-18.5, Moderate: BMI 16.0-16.99, Severe/Extreme: BMI ≤ 15.99. [2] These BMI classifications correlate approximately with ideal body weight calculations.
c. Adult patients are defined as patients who are greater than 18 years of age.
d. Pediatric patients are defined as patients 8 to 18 years of age.
e. The pediatric patient's weight is assessed using the patient's expected body weight (EBW) and BMI method. [12-15]
f. See Appendix C for definitions of psychological terms, including motivation and social support.
g. Common co-morbid disorders include depression, anxiety and substance abuse.[1,4]

Patients Eligible for Management in Ambulatory Setting

Pediatric patients who are greater than the 3rd percentile for BMI-for-age and/or following his or her established personal growth curve and/or adult patients who are greater than or equal to 85% of his or her expected body weight [11-15] and motivated to adhere to treatment, have cooperative families, and have a brief symptom duration may benefit from treatment in the outpatient setting, but only if they are carefully monitored and understand that a more restrictive setting may be necessary if persistent progress is not evident in a few weeks.[1] *(APA Grade II)*

Patients who are assessed and deemed appropriate for MNT in the ambulatory setting (Level of Care 1), will have concurrent appointments with a mental healthcare provider, coexisting medical care from a UW Health physician and meet the minimum weight guideline prior to being seen by a UW Health RDN. The RDN will have the scheduler call the patient to set up the appointment(s).

Patients Ineligible for Management in Ambulatory Setting

Factors which suggest that hospitalization may be appropriate include rapid or persistent decline in oral intake, decline in weight despite maximally intensive outpatient interventions, the presence of additional stressors that interfere with the patient's ability to eat, knowledge of weight at which instability previously occurred, co-occurring psychiatric problems, large degree of denial or resistance to participate in less intensive settings, and signs and symptoms of medical instability.[1] *(APA Grade I)*

Patients assessed to be at Level of Care 2 or 3 are inappropriate for treatment management in the ambulatory setting. If the patient is deemed inappropriate, the ambulatory RDN will inform the patient of the intensive care options, refer them back to their medical provider to assist with arranging care, and encourage the patient to contact their health insurer to determine coverage for intensive care.

Local external resources for Levels of Care 2 and 3 include:

- *Roger's Memorial Hospital (Oconomowoc, WI)*
  Rogers Memorial Hospital has an effective phone screening process to evaluate eating disorder severity and provide guidance for the appropriate level of care for inpatient and admissions. The RDN can refer the patient to this resource's free screening by encouraging them to call (800) 767-4411 or request a screening online at www.RogersHospital.org.
- *Aurora Psychiatric Hospital (Wauwatosa, WI)*
  www.aurora.org/ed
- *Timberline Knolls Residential Treatment Center (Lemont, IL)*
  http://www.timberlineknolls.com

Additional treatment program and support group options can be viewed at

- National Eating Disorder Association's website.

Special Considerations

All ambulatory RDN's will be instructed on pertinent UW Health policies and procedures related to suicidal ideation and implied risk of suicidal behavior, including:

1. UWMF Policy – MF Person at Risk for Suicide
2. UWHC Policy 10.10 – Suicide Assessment and Prevention
3. UWHC Policy 8.14 – Suicide Assessment and Intervention in Clinic
4. UWHC Policy 10.22 – Admission & Discharge of Patients To & From the Inpatient Psychiatric Unit

UW Health Implementation

Potential Benefits:

Standardization of the care setting for patients diagnosed with an eating disorder.

Potential Harms: NA

Implementation Plan/Tools

1. Guideline will be housed on U-Connect in a dedicated folder for clinical practice guidelines.
2. Release of the guideline will be advertised in the:
    a. Clinical Knowledge Management Corner within the Best Practice newsletter.
    b. Department of Culinary and Clinical Nutrition Services weekly newsletter
3. Notice will communicated via the following departments' listservs:
    a. Department of Family Medicine
    b. Department of Psychology
    c. Department of Psychiatry
    d. Department of Social Work
    e. Department of General Pediatrics and Adolescent Medicine
    f. Department of Culinary and Clinical Nutrition Services
4. Links to this guideline will be updated and/or added in Health Link or equivalent tools. This may include smart set, e-referral, or consult order with specific questions.

Disclaimer

CPGs are described to assist clinicians by providing a framework for the evaluation and treatment of patients. This Clinical Practice Guideline outlines the preferred approach for most patients. It is not intended to replace a clinician's judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

References

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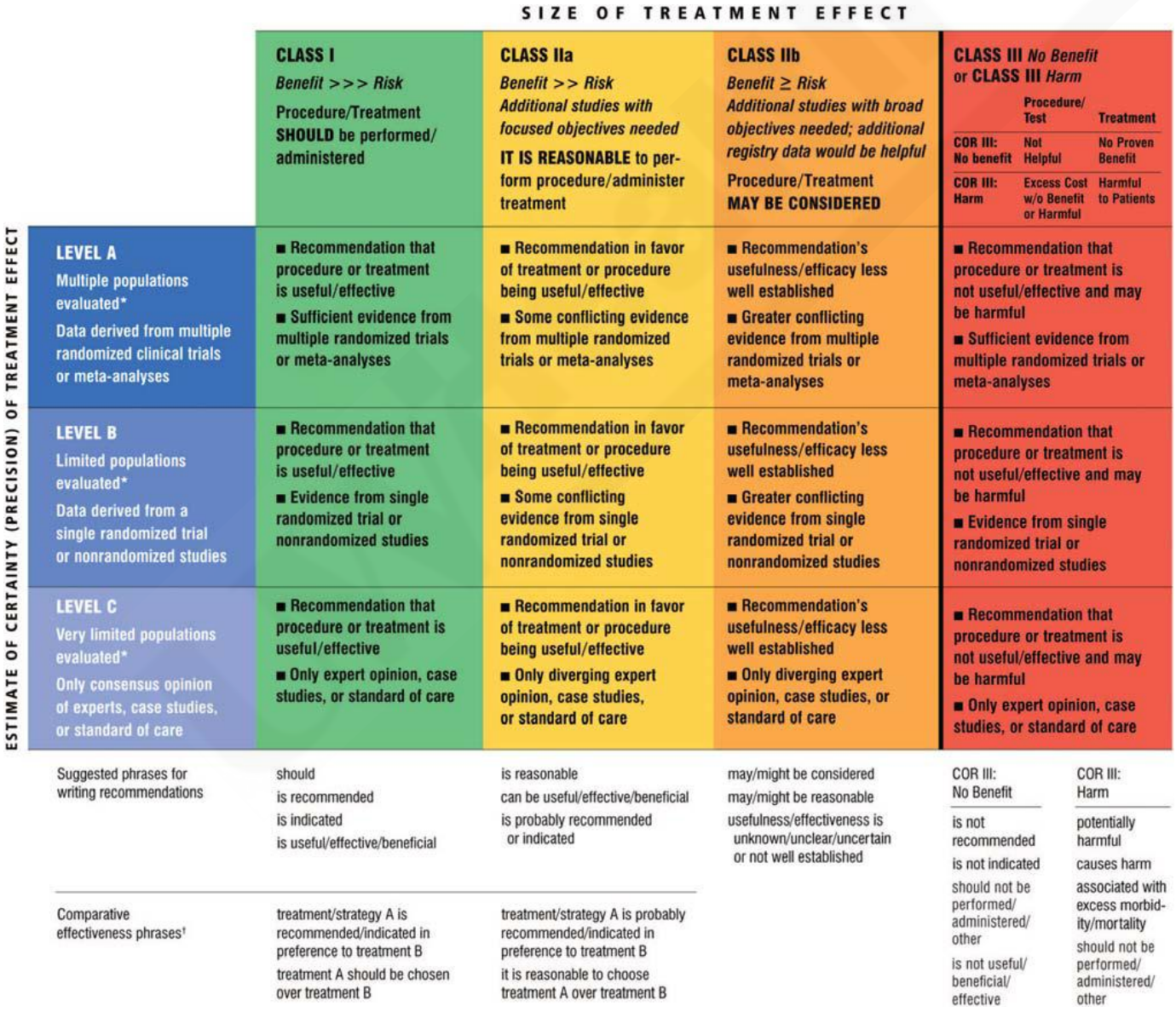
Appendix A. Grading Schemes

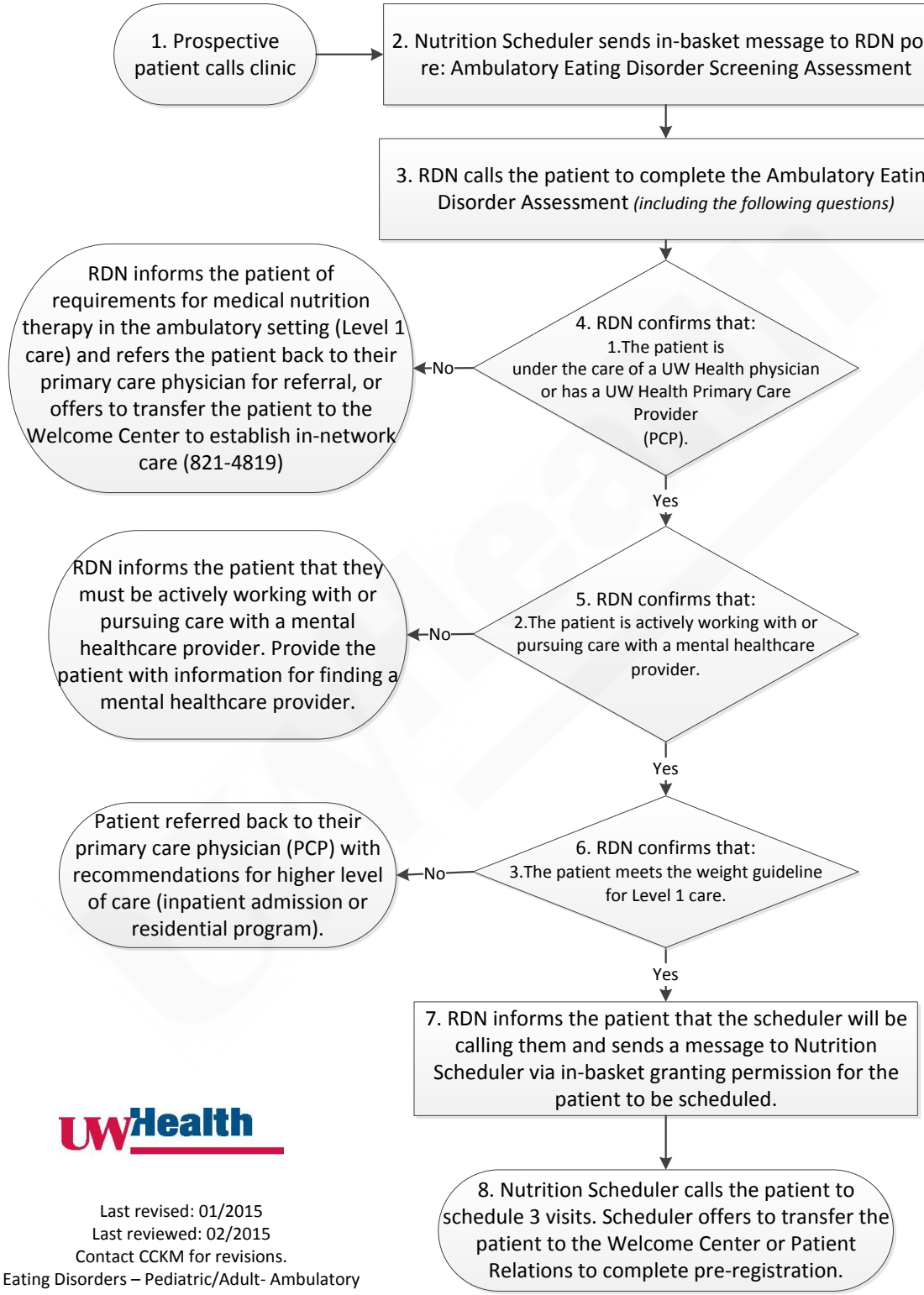
Figure 1. APA Grading Scheme

I	Recommend with substantial clinical confidence.
II	Recommend with moderate clinical confidence.
III	May be recommended on the basis of individual circumstances.

Figure 2. GRADE Grading Scheme (Modified by AHA/ACC)



Appendix B. Nutrition Scheduling Algorithm Patients with an Eating Disorder



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Contact CCKM for revisions.
Eating Disorders – Pediatric/Adult- Ambulatory Clinical Practice Guideline

Appendix C. Glossary of Psychological Terms

Anorexia Nervosa: An eating disorder in which an individual weighs less than 85 percent of her or his expected weight but still controls eating because of a self-perception of obesity.

Bulimia Nervosa: An eating disorder characterized by binge eating followed by measures to purge the body of the excess calories.

Comorbidity: The experience of more than one disorder at the same time.

Motivation: The process of starting, directing, and maintaining physical and psychological activities; includes mechanisms involved in preferences for one activity over another and the vigor and persistence of responses.

Social Support: Resources, including material aid, socio-emotional support, and informational aid, provided by others to help a person cope with stress.

Key terms as defined by Gerrig & Zimbardo (2002).[5]