TABLE 8. 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, hypokalemia,[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

TABLE 8. Level of Care Guidelines for Patients With Eating Disorders *(continued)*

	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
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
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

TABLE 8. Level of Care Guidelines for Patients With Eating Disorders *(continued)*

	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
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	

Source. Adapted and modified from La Via et al. (100).

Note. In general, a given level of care should be considered for patients who meet one or more criteria under a particular level. These guidelines are not absolutes, however, and their application requires physician judgment.

[a]This level of care is most effective if administered for at least 8 hours/day, 5 days/week; less intensive care is demonstrably less effective (101).

[b]If the patient is dehydrated, whole-body potassium values may be low even if the serum potassium value is in the normal range; determine concurrent urine specific gravity to assess for dehydration.

[c]Determining suicide risk is a complex clinical judgment, as is determining the most appropriate treatment setting for patients at risk for suicide. Relevant factors to consider are the patient's concurrent medical conditions, psychosis, substance use, other psychiatric symptoms or syndromes, psychosocial supports, past suicidal behaviors, and treatment adherence and the quality of existing physician-patient relationships. These factors are described in greater detail in the APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* (84).

[d]Although this table lists percentages of expected healthy body weight in relation to suggested levels of care, these are only approximations and do not correspond to percentages based on standardized values for the population as a whole. For any given individual, differences in body build, body composition, and other physiological variables may result in considerable differences as to what constitutes a healthy body weight in relation to "norms." For example, for some patients, a healthy body weight may be 110% of the standardized value for the population, whereas for other individuals it may be 98%. Each individual's physiological differences must be assessed and appreciated. For children, also consider the rate of weight loss. Finally, weight level per se should never be used as the sole criterion for discharge from inpatient care. Many patients require inpatient admission at higher weights and should not be automatically discharged just because they have achieved a certain weight level unless all other factors are appropriately considered. See text for further discussion regarding weight.

[e]Individuals may experience these thoughts as consistent with their own deeply held beliefs (in which case they seem to be ego-syntonic and "overvalued") or as unwanted and ego-alien repetitive thoughts, consistent with classic obsessive-compulsive disorder phenomenology.