Eating Disorder

Christine Skurkis, MD
Lisa Namerow, MD
Alyssa Bennett, MD
Dakota Michaud, RD

Connecticut Children's

What is a Clinical Pathway?

Connecticut Children's

An evidence-based guideline that decreases unnecessary variation and helps promote safe, effective, and consistent patient care.

Objectives of Pathway

Connecticut Children's

- Restart nutrition in a safe manner to prevent refeeding syndrome
- Promote patient weight gain and gradual medical stability in a structured manner
- Provide appropriate treatment for the patient's medical needs and begin to address underlying psychiatric causes

- Some admissions for medical stabilization are entirely focused on giving the patient nutrition. Our pathway is focused on
  - → encouraging the patient to take the nutrition by mouth
  - → simultaneous medical and psychological care

Why is Pathway Necessary?

Connecticut Children's

- To achieve the following goals:
  - Reinitiate nutrition in a safe environment
  - Prevent Refeeding Syndrome
  - Gain or maintain weight with increasing activity (based on patient goal)
  - Develop a discharge plan with appropriate referrals
  - Streamline care between the ED and the inpatient floors

Refeeding Syndrome

Connecticut Children's

- A shift from fat to carbohydrate metabolism occurs, evoking insulin release → increasing cellular uptake of glucose, phosphate, potassium, magnesium, and water → further depletion
- Predominant features
  - Hypophosphatemia
  - Hypokalemia
  - Hypomagnesemia
  - Hypocalcemia
- Any sugar including dextrose containing IVFs can cause refeeding'
- Dehydration should be treated with isotonic fluids without dextrose

2026 Updates – Page 1 of Algorithm

Connecticut Children's

- Inclusion criteria- clarified "suspected" eating disorder
- Inclusion criteria- removed moderate to severe malnutrition requirement
- Calculate % goal BMI rather than % median BMI for classification of malnutrition
- Pre-treatment labs- changed TTG IgA to celiac disease panel based on changes in HH lab testing, added zinc and vitamin D for all patients. Added vitamin B12 for vegans
- Clarified ED treatment to including offering patient food, replacing electrolytes and to reserve isotonic IV boluses for significant dehydration
- Admission criteria- added >25% weight loss to capture malnourished patients with atypical anorexia with significant weight loss who may not show other signs of malnutrition but are at high risk
- Admission criteria- removed hypothermia from criteria for admission
- Admission criteria- changed pre-syncope to near syncope
- Added reminder that patients with ARFID should have OT + SLP (feeding team) consult placed on admission

2026 Updates – Page 2-3 of Algorithm

- Vitals- Clarified instructions for orthostatics and when to discontinue (left intentionally vague)
- Vitals- Added CP monitor instructions to anorexia and changed when to discontinue
- Vitals- Added to not share BMI with patient or parent and that parent can be told trend
- Diagnostics- Added specific criteria for when to consider echocardiogram
- Labs- Removed reminder to complete UA and Urine preg if not performed in the ED and added when to consider first morning urine specific gravity
- Labs- Clarified confusion regarding how many days to get labs (6 days including morning of pathway step 1)
- Nutrition- Step 1 starts with 1800 calories instead of 1500 calories
- Nutrition- Gave more explicit instructions to advance nutrition daily
- Fluids- Changed IVF recommendation to isotonic boluses and removed recommendation for continuous IVFs

2026 Updates – Page 2-3 of Algorithm

Connecticut Children's

- Meds- Clarified that top list meds are for bulimia in addition to anorexia
- Meds- Clarified instructions to replete calcium, phos and potassium based on levels for age
- Meds- Added recommendations treating for constipation
- Activity level- Changed activity levels to start most patients at out of bed to chair- new level 1, old level 2
- Activity level- Clarified recommendations for when to advance activity level, daily if meeting criteria
- Discharge- Added and clarified discharge instructions including continued weight gain with maximum activity level and stable electrolytes, adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80, scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy, and if being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed

2026 Updates - Appendix

Connecticut Children's

- Instructions for how to calculate % of Goal BMI (rather than % median BMI)
- Step 1 nutrition will be 1800 calories instead of 1500 calories and the steps will continue at the same 300 calorie increase
- Included a general weight gain goal of 0.2 kg/day or 3 pounds per week
- Clarified difference between nutrition observation and safety risk observation
- Observation duration after meals and snacks is 1 hour including for those with purging which was previously 2 hours
- Clarified observer role
- Added how to calculate makeup if patient is receiving 45 cal/oz supplement
- Patient handout edited to include- estimate of length of stay, info about daily labs, explanation of what they are signing "The Patient Handout was reviewed with me and I understand the recommended treatment plan", guardian signature for patients < 18 years

Nutrition vs. Safety Risk Observation

Connecticut Children's

- An eating disorder patient will have 2 observation orders, one for nutrition and one for safety risk
- Nutrition observation is specific to patients with eating disorders and for observing meals to document intake, observing for eating disorder behaviors including hiding food or manipulating NG tube, and to provide support during and after meals and snacks
- Safety risk observation is for patients at risk of harm to self or others and is ordered using the safety risk order (none, mild, moderate or severe)

This is the Eating Disorder Clinical Pathway.

We will be reviewing each component in the following slides.

CLINICAL PATHWAY:

Eating Disorder

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Established or newly diagnosed/suspected eating disorder
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

PCP and/or ED Assessment

- **History of:** weight loss, binging/purging, diet, alcohol, substance use, meds, exercise, syncope, menstrual periods
- **Physical exam:** measure height & weight, calculate % Goal BMI (see Appendix A), perform orthostatic vitals (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), assess hydration status, cardiac and peripheral exam

Pre-Treatment Evaluation and Interventions

- Chem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, free T4 & TSH, albumin, pre-albumin, CBC w/diff, ESR, total IgA, celiac disease panel, zinc, Vitamin D, UA, urine for hCG, 12-lead EKG.
- If vegan, add vitamin B12.
- Always repeat Chem 10, otherwise if tests were recently completed, use provider discretion whether to repeat.
- Offer patient food. Replace electrolytes. NS/LR bolus only for significant dehydration (dextrose may cause refeeding).

Admission Criteria [1]

[1] **Admission Criteria**:
Must meet inclusion criteria ***AND*** *one or more of the following criteria secondary to the eating disorder:*

- % Goal BMI of < 75% OR % Goal BMI of < 80% if < 10 years old or pre-menarchal
- >25% weight loss
- Acute food refusal > 24hrs
- HR ≤40 bpm supine & resting
- Systolic BP <80 mmHg
- Orthostatic changes in SBP (>20 mmHg)
- Syncope or near syncope with standing
- Electrolyte disturbances
- Moderate or severe Dehydration
- Arrhythmia including prolonged QTc
- Intractable vomiting or hematemesis
- Failure of outpatient treatment

No:

- Notify PCP
- Consider behavioral health consult for partial hospitalization programs or outpatient counseling
- May always call Psychiatry or Hospital Medicine to discuss

Yes:

Admit to Hospital Medicine

- PCP or ED provider reviews clinical pathway management with patient and family [2]
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient ≥ 18 years, must call hospitalist to discuss admission

Inpatient Initial Management

- Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)
- Place patient in 1:1 observation (per Appendix B)
- Place patient on continuous CR monitoring
- Order strict I/O's
- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
  - Psychiatry consult for all patients
  - Nutrition consult for all patients
  - Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI, or is an established GI patient
  - Consult OT + SLP (feeding team) for ARFID[3] patients
- Nurse or observer to print Nursing/observer Job Aid (Appendix B) and Nursing/observer Protocol Worksheet (Appendix I)

If Anorexia/Bulimia:

- Proceed to page 2: Anorexia/Bulimia Inpatient Management

If Avoidant Restrictive Food Intake Disorder (ARFID)[3]:

- Proceed to page 3: ARFID Inpatient Management

[2] **Example script for ED when notifying of admission**:

"Your child is being admitted for medical stabilization for malnutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re-introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."

[3] **Avoidant Restrictive Food Intake Disorder (ARFID) Definition**:

Disordered eating due to one of the following:

- Concern about unpleasant consequences of eating, such as pain, vomiting, choking
- Avoidance based on sensory qualities
- Seeming lack of interest in eating or food

NEXT PAGE

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

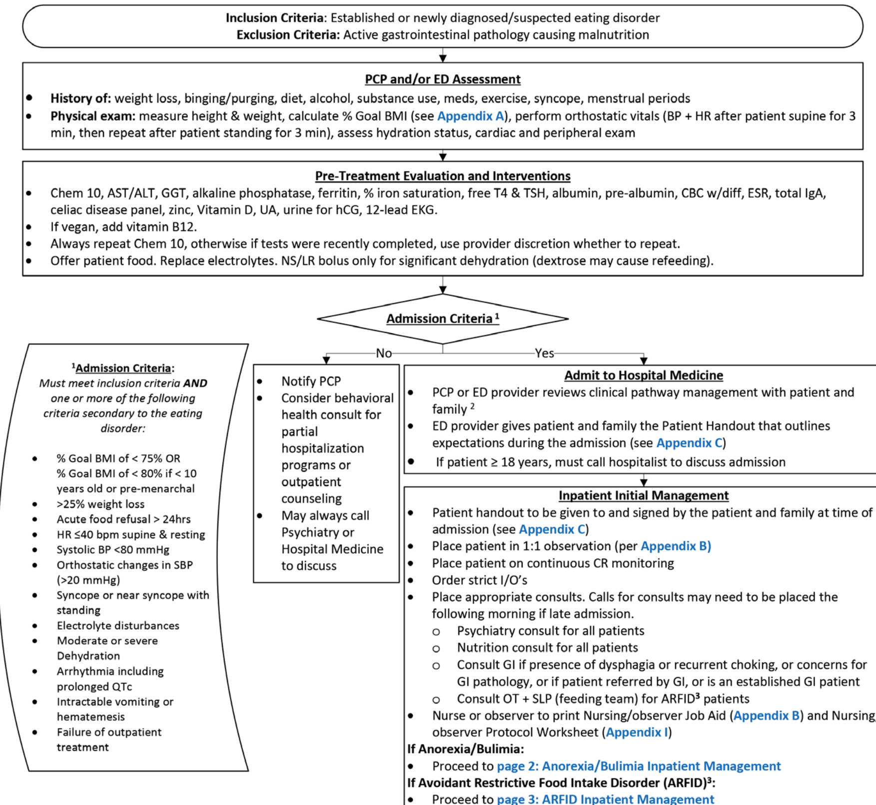
LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

- The Eating Disorder pathway starts with a common first page, and then divides care for Anorexia/Bulimia (page 2), and Avoidant Restrictive Food Intake Disorder - ARFID (page 3)
- There is also an Appendix with clarifying details, the patient handout, and observer tools
- This is page 1 of the Eating Disorder Clinical Pathway
- We will be reviewing each component in the following slides

CLINICAL PATHWAY:
Eating Disorder

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.



[2] Example script for ED when notifying of admission:

"Your child is being admitted for medical stabilization for malnutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re-introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."

[3] Avoidant Restrictive Food Intake Disorder (ARFID) Definition:

Disordered eating due to one of the following:
- Concern about unpleasant consequences of eating, such as pain, vomiting, choking
- Avoidance based on sensory qualities
- Seeming lack of interest in eating or food

NEXT PAGE

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.

CLINICAL PATHWAY:
Eating Disorder

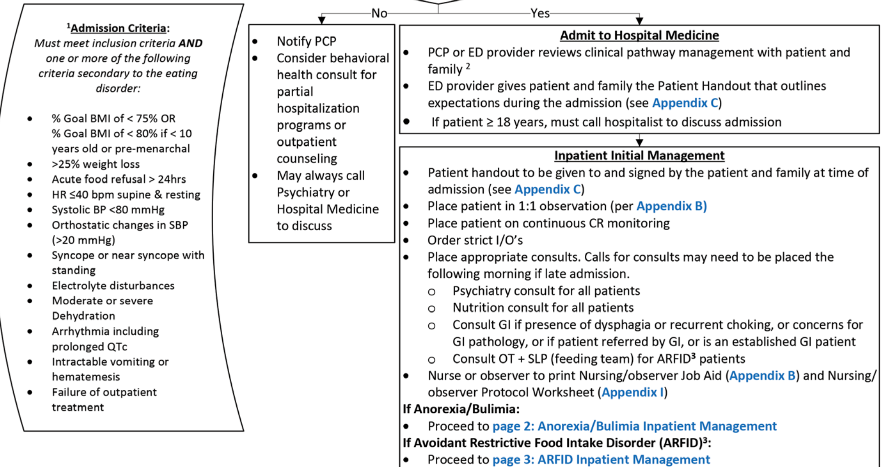
THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Established or newly diagnosed/suspected eating disorder
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

PCP and/or ED Assessment

Inclusion Criteria: Established or newly diagnosed/suspected eating disorder
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

celiac disease panel, zinc, Vitamin D, UA, urine for hCG, 12-lead EKG.
- If vegan, add vitamin B12.
- Always repeat Chem 10, otherwise if tests were recently completed, use provider discretion whether to repeat.
- Offer patient food. Replace electrolytes. NS/LR bolus only for significant dehydration (dextrose may cause refeeding).



[2] Example script for ED when notifying of admission:

"Your child is being admitted for medical stabilization for malnutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re-introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."

[3] Avoidant Restrictive Food Intake Disorder (ARFID) Definition:

Disordered eating due to one of the following:
- Concern about unpleasant consequences of eating, such as pain, vomiting, choking
- Avoidance based on sensory qualities
- Seeming lack of interest in eating or food

Inclusion Criteria:

Patient with stablished or newly diagnosed/ suspected eating disorder
- Added "suspected"
- Removed minimum malnutrition requirement

Exclusion Criteria:

Active gastrointestinal pathology causing malnutrition (unchanged)

NEXT PAGE

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

CLINICAL PATHWAY:

Eating Disorder

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Established or newly diagnosed/suspected eating disorder
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

PCP and/or ED Assessment

- **History of:** weight loss, binging/purging, diet, alcohol, substance use, meds, exercise, syncope, menstrual periods
- **Physical exam:** measure height & weight, calculate % Goal BMI (see Appendix A), perform orthostatic vitals (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), assess hydration status, cardiac and peripheral exam

PCP and/or ED Assessment

- **History of:** weight loss, binging/purging, diet, alcohol, substance use, meds, exercise, syncope, menstrual periods
- **Physical exam:** measure height & weight, calculate % Goal BMI (see Appendix A), perform orthostatic vitals (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), assess hydration status, cardiac and peripheral exam

Prior to admission:

- Complete a thorough history and physical with all of the elements outlined.
- Appendix A is a guide to help calculate the patient's % Goal BMI

[1]**Admission Criteria**:
*Must meet inclusion criteria **AND** one or more of the following criteria secondary to the eating disorder:*

- % Goal BMI of < 75% OR % Goal BMI of < 80% if < 10 years old or pre-menarchal
- >25% weight loss
- Acute food refusal > 24hrs
- HR ≤40 bpm supine & resting
- Systolic BP <80 mmHg
- Orthostatic changes in SBP (>20 mmHg)
- Syncope or near syncope with standing
- Electrolyte disturbances
- Moderate or severe Dehydration
- Arrhythmia including prolonged QTc
- Intractable vomiting or hematemesis
- Failure of outpatient treatment

- Notify PCP
- Consider behavioral health consult for partial hospitalization programs or outpatient counseling
- May always call Psychiatry or Hospital Medicine to discuss

Admit to Hospital Medicine

- PCP or ED provider reviews clinical pathway management with patient and family [2]
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient ≥ 18 years, must call hospitalist to discuss admission

Inpatient Initial Management

- Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)
- Place patient in 1:1 observation (per Appendix B)
- Place patient on continuous CR monitoring
- Order strict I/O's
- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
  - Psychiatry consult for all patients
  - Nutrition consult for all patients
  - Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI, or is an established GI patient
  - Consult OT + SLP (feeding team) for ARFID[3] patients
- Nurse or observer to print Nursing/observer Job Aid (Appendix B) and Nursing/observer Protocol Worksheet (Appendix I)

If Anorexia/Bulimia:
- Proceed to page 2: Anorexia/Bulimia Inpatient Management

If Avoidant Restrictive Food Intake Disorder (ARFID)[3]:
- Proceed to page 3: ARFID Inpatient Management

[2] **Example script for ED when notifying of admission:**

"Your child is being admitted for medical stabilization for malnutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re-introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."

[3] **Avoidant Restrictive Food Intake Disorder (ARFID) Definition:**

Disordered eating due to one of the following:
- Concern about unpleasant consequences of eating, such as pain, vomiting, choking
- Avoidance based on sensory qualities
- Seeming lack of interest in eating or food

NEXT PAGE

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.

PCP and/or ED Assessment

- **History of:** weight loss, binging/purging, diet, alcohol, substance use, meds, exercise, syncope, menstrual periods
- **Physical exam:** measure height & weight, calculate % Goal BMI (see **Appendix A**), perform orthostatic vitals (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), assess hydration status, cardiac and peripheral exam

Appendix A: Guide to Calculating % Goal BMI

- Review patient's growth chart to determine approximate BMI percentile trajectory prior to onset of their eating disorder

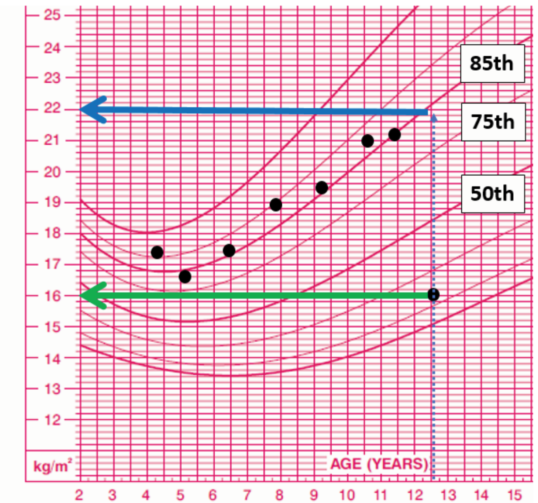
OR

- If no historical weights are available, calculate % of median BMI using the 50th%

Steps:

1. Review patient's growth chart to determine approximate BMI percentile trajectory prior to onset of their eating disorder (*Goal BMI percentile*)
2. Using the BMI growth chart in Epic, find the BMI that corresponds to the goal BMI percentile (*Goal BMI*) for their current age
3. Calculate % of Goal BMI: current BMI ÷ Goal BMI

- **Step 1: Goal BMI percentile = 85th**
- **Step 2: Goal BMI: 22**
- **Step 3: % of Goal BMI = current BMI/Goal BMI = 16/22 = 73%**



*If no historical weights are available, calculate % of median BMI using the following method:

1. Visit www.peditools.org
2. Select "CDC Growth Calculator for 2 to 20 years"
3. Enter pt data (DOB, Measurement date, gender, height, weight) then Submit
4. Calculate % median BMI by taking current weight and dividing by "Weight for 50th percentile BMI"

You can substitute % median BMI for % Goal BMI for admission criteria.

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Connecticut Children's

Pre-Treatment Evaluation and Interventions

- Chem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, free T4 & TSH, albumin, pre-albumin, CBC w/diff, ESR, total IgA, celiac disease panel, zinc, Vitamin D, UA, urine for hCG, 12-lead EKG.
- If vegan, add vitamin B12.
- Always repeat Chem 10, otherwise if tests were recently completed, use provider discretion whether to repeat.
- Offer patient food. Replace electrolytes. NS/LR bolus only for significant dehydration (dextrose may cause refeeding).

Pre-treatment evaluation:

- Patients may come to the ED with some or all of this work-up done by their primary care physician. It is at the provider's discretion whether to repeat or not
- Chem 10 should always be repeated
- Be sure to consider findings identified by the PCP- For example, a patient with bradycardia in the PCP's office may not be in the ED due to anxiety
- Replace electrolyte deficiencies
- If any delays in obtaining inpatient bed, initiate pathway from the ED (patient should not miss meal, initiate nutrition observation)

CLINICAL PATHWAY:

Eating Disorder

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Established or newly diagnosed/suspected eating disorder
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

after patient supine for 3

/diff, ESR, total IgA,

[1] **Admission Criteria**:
Must meet inclusion criteria AND one or more of the following criteria secondary to the eating disorder:

- % Goal BMI of < 75% OR % Goal BMI of < 80% if < 10 years old or pre-menarchal
- >25% weight loss
- Acute food refusal > 24hrs
- HR ≤40 bpm supine & resting
- Systolic BP <80 mmHg
- Orthostatic changes in SBP (>20 mmHg)
- Syncope or near syncope with standing
- Electrolyte disturbances
- Moderate or severe Dehydration
- Arrhythmia including prolonged QTc
- Intractable vomiting or hematemesis
- Failure of outpatient treatment

No

- Notify PCP
- Consider behavioral health consult for partial hospitalization programs or outpatient counseling
- May always call Psychiatry or Hospital Medicine to discuss

Yes

Admit to Hospital Medicine

- PCP or ED provider reviews clinical pathway management with patient and family [2]
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient ≥ 18 years, must call hospitalist to discuss admission

Inpatient Initial Management

- Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)
- Place patient in 1:1 observation (per Appendix B)
- Place patient on continuous CR monitoring
- Order strict I/O's
- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
  - Psychiatry consult for all patients
  - Nutrition consult for all patients
  - Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI, or is an established GI patient
  - Consult OT + SLP (feeding team) for ARFID[3] patients
- Nurse or observer to print Nursing/observer Job Aid (Appendix B) and Nursing/observer Protocol Worksheet (Appendix I)

If Anorexia/Bulimia:
- Proceed to page 2: Anorexia/Bulimia Inpatient Management

If Avoidant Restrictive Food Intake Disorder (ARFID)[3]:
- Proceed to page 3: ARFID Inpatient Management

[2] **Example script for ED when notifying of admission**:

"Your child is being admitted for medical stabilization for malnutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re-introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."

[3] **Avoidant Restrictive Food Intake Disorder (ARFID) Definition:**

Disordered eating due to one of the following:
- Concern about unpleasant consequences of eating, such as pain, vomiting, choking
- Avoidance based on sensory qualities
- Seeming lack of interest in eating or food

NEXT PAGE

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.

CLINICAL PATHWAY:

Eating Disorder

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Pre-Treatment Evaluation and Interventions

- Chem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, free T4 & TSH, albumin, pre-albumin, CBC w/diff, ESR, total IgA, celiac disease panel, zinc, Vitamin D, UA, urine for hCG, 12-lead EKG.
- If vegan, add vitamin B12.
- Always repeat Chem 10, otherwise if tests were recently completed, use provider discretion whether to repeat.
- Offer patient food. Replace electrolytes. NS/LR bolus only for significant dehydration (dextrose may cause refeeding).

Admission Criteria [1]

Admission Criteria to the pathway:

- In addition to having a new, suspected, or previous diagnosis of eating disorder, the patient must meet 1 or more criteria which are secondary to the eating disorder
- Ex. A patient with viral gastro and dehydration may need admission, but not to the eating disorder pathway
- There is no longer a minimum malnutrition requirement
- >25% weight loss is a new criteria (there is no specified duration of time)

[1]**Admission Criteria:**
*Must meet inclusion criteria **AND** one or more of the following criteria secondary to the eating disorder:*

- % Goal BMI of < 75% OR % Goal BMI of < 80% if < 10 years old or pre-menarchal
- >25% weight loss
- Acute food refusal > 24hrs
- HR ≤40 bpm supine & resting
- Systolic BP <80 mmHg
- Orthostatic changes in SBP (>20 mmHg)
- Syncope or near syncope with standing
- Electrolyte disturbances
- Moderate or severe Dehydration
- Arrhythmia including prolonged QTc
- Intractable vomiting or hematemesis
- Failure of outpatient treatment

No

- Notify PCP
- Consider behavioral health consult for partial hospitalization programs or outpatient counseling
- May always call Psychiatry or Hospital Medicine to discuss

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW,

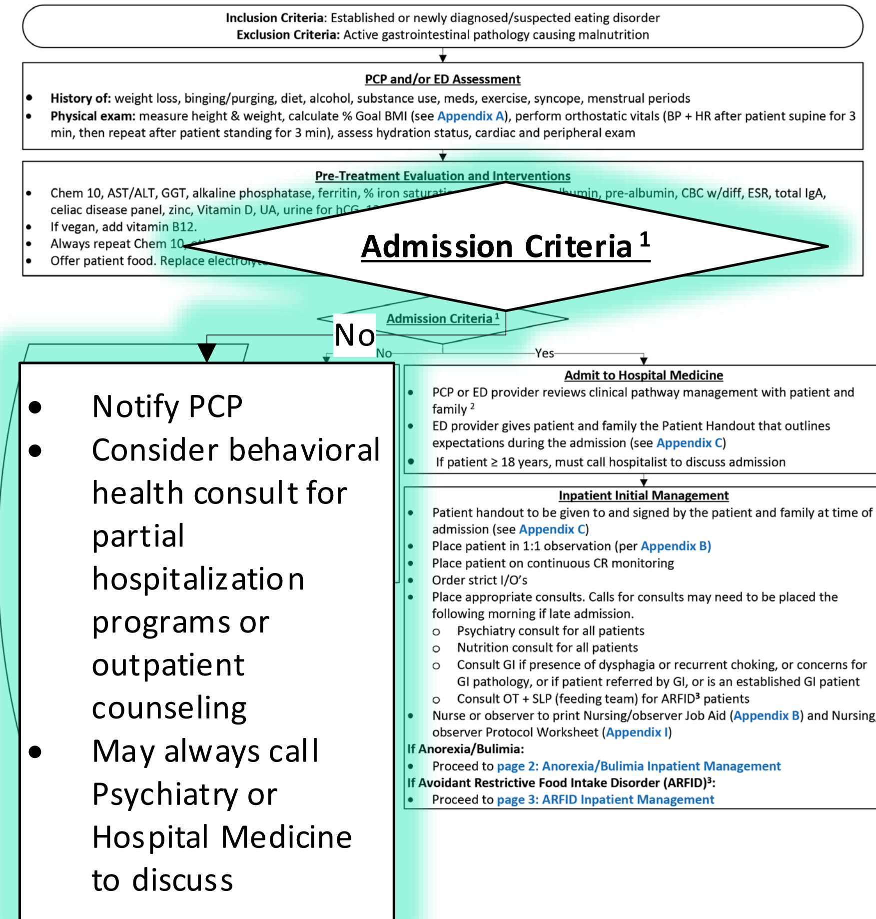
LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Connecticut Children's

Admission Criteria:

If the patient does not meet inpatient criteria, consider behavioral health consult for disposition planning



CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.

CLINICAL PATHWAY:

Eating Disorder

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Established or newly diagnosed/suspected eating disorder
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

PCP and/or ED Assessment

- History of: weight loss, binging/purging, diet, alcohol, substance use, meds, exercise, syncope, menstrual periods
- Physical exam: measure height & weight, calculate % Goal BMI (see Appendix A), perform orthostatic vitals (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), assess hydration status, cardiac and peripheral exam

Admission Criteria [1]

Yes

Admit to Hospital Medicine

- PCP or ED provider reviews clinical pathway management with patient and family [2]
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient ≥ 18 years, must call hospitalist to discuss admission

Inpatient Initial Management

- Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)
- Place patient in 1:1 observation (per Appendix B)
- Place patient on continuous CR monitoring
- Order strict I/O's
- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
  - Psychiatry consult for all patients
  - Nutrition consult for all patients
  - Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI, or is an established GI patient
  - Consult OT + SLP (feeding team) for ARFID[3] patients
- Nurse or observer to print Nursing/observer Job Aid (Appendix B) and Nursing/observer Protocol Worksheet (Appendix I)

If Anorexia/Bulimia:

- Proceed to page 2: Anorexia/Bulimia Inpatient Management

If Avoidant Restrictive Food Intake Disorder (ARFID)[3]:

- Proceed to page 3: ARFID Inpatient Management

[2] **Example script for ED when notifying of admission:**

"Your child is being admitted for medical stabilization for malnutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re-introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."

If patient admitted:

- Early communication and expectation setting is critical to success
- ED provider reviews clinical pathway management with patient and family
  - See example script
- ED provider gives patient and family the patient handout that outlines what to expect during the admission
  - See Appendix C
- If patient ≥18 years, ED must call hospitalist to discuss admission

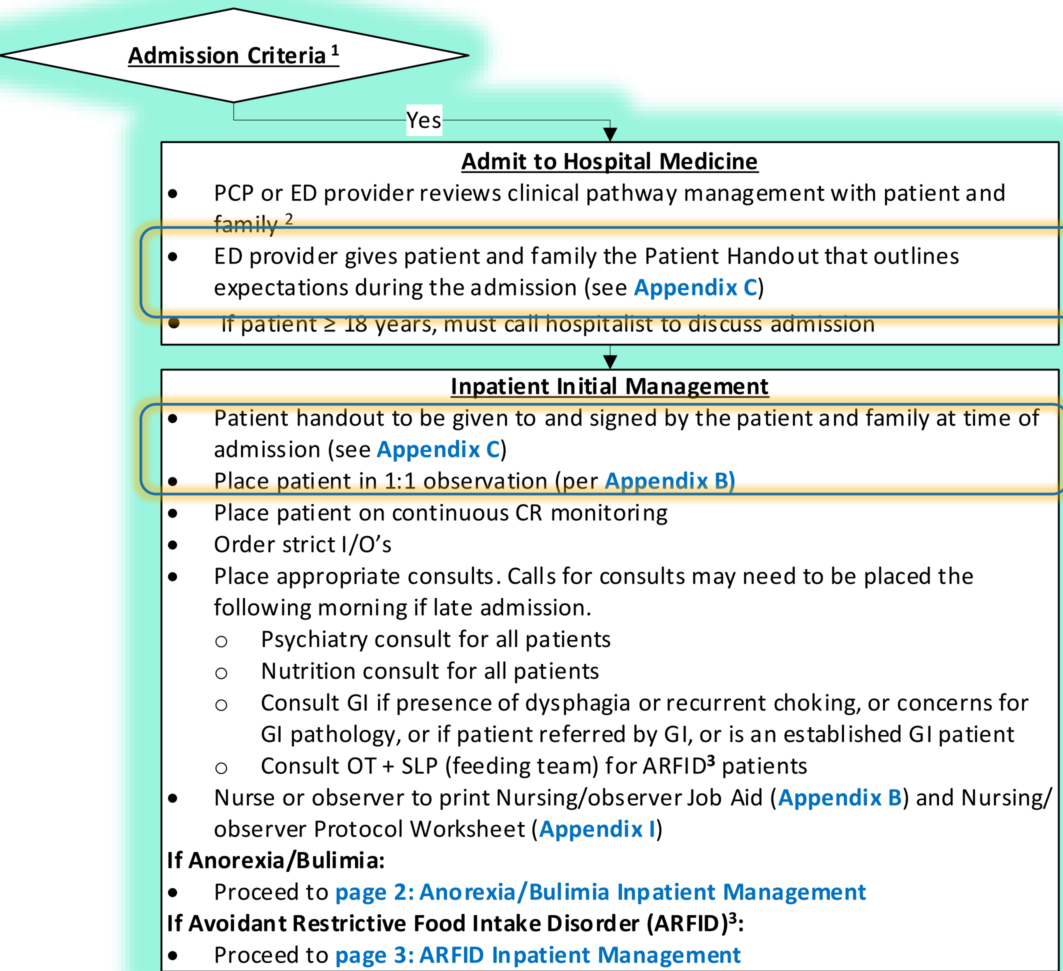
NEXT PAGE

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.



Appendix C: The Patient Handout

- This is a 3 page document given to the patient and family in the ED
- It must be signed by patient and family on admission
- The is a separate page for patients > 18 years old
- Explains and reinforces reasons for admission, treatment goals, and patient expectations

3. Staff will check your tray for accuracy prior to each meal. No food substitutions are allowed.
4. You will have 30 minutes to complete each meal or snack. After that time, the tray will be removed from your room.
5. Approximate meal times are:
   - Breakfast = 8:00am – 8:30am
   - Snack = 10:00am – 10:30am
   - Lunch = 12:00pm – 12:30pm
   - Snack = 2:30pm – 3:00pm
   - Dinner = 5:00pm – 5:30pm
   - Snack = 8:30pm – 9:00pm
6. Staff will record food intake on a meal ticket.
7. No other food, beverages, cups, or dishes are allowed in your room, including the food/beverage of family members.
8. 100% compliance with daily nutrition (food & water) is expected.
9. If you are unable to eat/drink all of the food and liquids presented, you will have the opportunity to take in the missed nutrition from a meal at the next snack by drinking a nutrition supplement.
10. If you are unable to make up the nutrition from the liquid nutrition supplement, a feeding tube, also called a Nasogastric Tube (NGT) will be placed. The feeding tube will be placed at the end of each snack time if you do not consume the goal nutrition for that snack and the prior meal. The remainder of the nutrition will be provided with a nutrition supplement via feeding tube. The feeding tube will be taken out when it is completed. You will then have a "fresh start" to be able to eat and drink all of the next meal and snack.
11. If you are on bedrest, you will eat meals in bed and must lay/sit on blankets. Otherwise you must eat sitting in a chair without blankets.

Unit Environment:

1. On admission, you will be placed on constant observation during and for one hour after meals/snacks, and if/when you have a feeding tube. *This means there will be a staff member with you to provide safety and support, and to monitor for any disordered eating behaviors.*
2. Bathroom use is supervised by staff with door open when on constant observation.
3. You will not have access to the family kitchen.
4. Lights must remain on during the day and bedside curtains must be kept open, except when dressing.
5. Staff will measure urine and stool output after each bathroom use.
6. You will be placed on constant observation for 24 hours a day, if you meet any of the following risk criteria during hospitalization:
   1. active suicidal ideation or safety risk behaviors that warrant constant observation
   2. concern for excessive exercise in treatment setting or home
   3. concern for water loading in treatment setting or home
   4. high fall risk
7. Inappropriate language or threatening behavior is not acceptable.
8. All medications brought from home must be given to your nurse upon admission.
9. We ask that families do not discuss meals, weight, or other eating-related topics, as these topics may increase anxiety. The treatment team will help guide your family as to appropriate discussions and meal support.

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.

Inpatient initial orders/care:

- Multidisciplinary approach involving patient and family, observers, RNs, Hospitalists, Psychiatry, Nutritionists, and other specialties as needed
- Observer job aid and the Nursing/ observer protocol worksheet are designed to help assist with workflow and pathway guidelines.
  - See Appendix B and I for these documents

CLINICAL PATHWAY:
Eating Disorder

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Established or newly diagnosed/suspected eating disorder
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

PCP and/or ED Assessment
- **History of:** weight loss, binging/purging, diet, alcohol, substance use, meds, exercise, syncope, menstrual periods
- **Physical exam:** measure height & weight, calculate % Goal BMI (see Appendix A), perform orthostatic vitals (BP + HR after patient supine for 3 ... then repeat after patient standing for 3 min), assess hydration status, cardiac and peripheral exam

Admission Criteria [1]

Pre-Treatment Evaluation and Interventions
- ...hem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, free T4 & TSH, albumin, pre-albumin, CBC w/diff, ESR, total IgA, celiac disease panel, zinc, Vitamin D, UA, urine for hCG, 12-lead EKG.
- If vegan, add vitam...
- Always repeat Chem 10, otherwise if tests were recently completed, use provider discretion whether to repeat.

Yes

Admit to Hospital Medicine
- PCP or ED provider reviews clinical pathway management with patient and family [2]
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient ≥ 18 years, must call hospitalist to discuss admission

Inpatient Initial Management
- Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)
- Place patient in 1:1 observation (per Appendix B)
- Place patient on continuous CR monitoring
- Order strict I/O's
- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
  - Psychiatry consult for all patients
  - Nutrition consult for all patients
  - Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI, or is an established GI patient
  - Consult OT + SLP (feeding team) for ARFID[3] patients
- Nurse or observer to print Nursing/observer Job Aid (Appendix B) and Nursing/ observer Protocol Worksheet (Appendix I)

If Anorexia/Bulimia:
- Proceed to page 2: Anorexia/Bulimia Inpatient Management

If Avoidant Restrictive Food Intake Disorder (ARFID)[3]:
- Proceed to page 3: ARFID Inpatient Management

[2] **Example script for ED when notifying of admission:**

"Your child is being admitted for medical stabilization for malnutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re-introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."

[3] **Avoidant Restrictive Food Intake Disorder (ARFID) Definition:**

Disordered eating due to one of the following:
- Concern about unpleasant consequences of eating, such as pain, vomiting, choking
- Avoidance based on sensory qualities
- Seeming lack of interest in eating or food

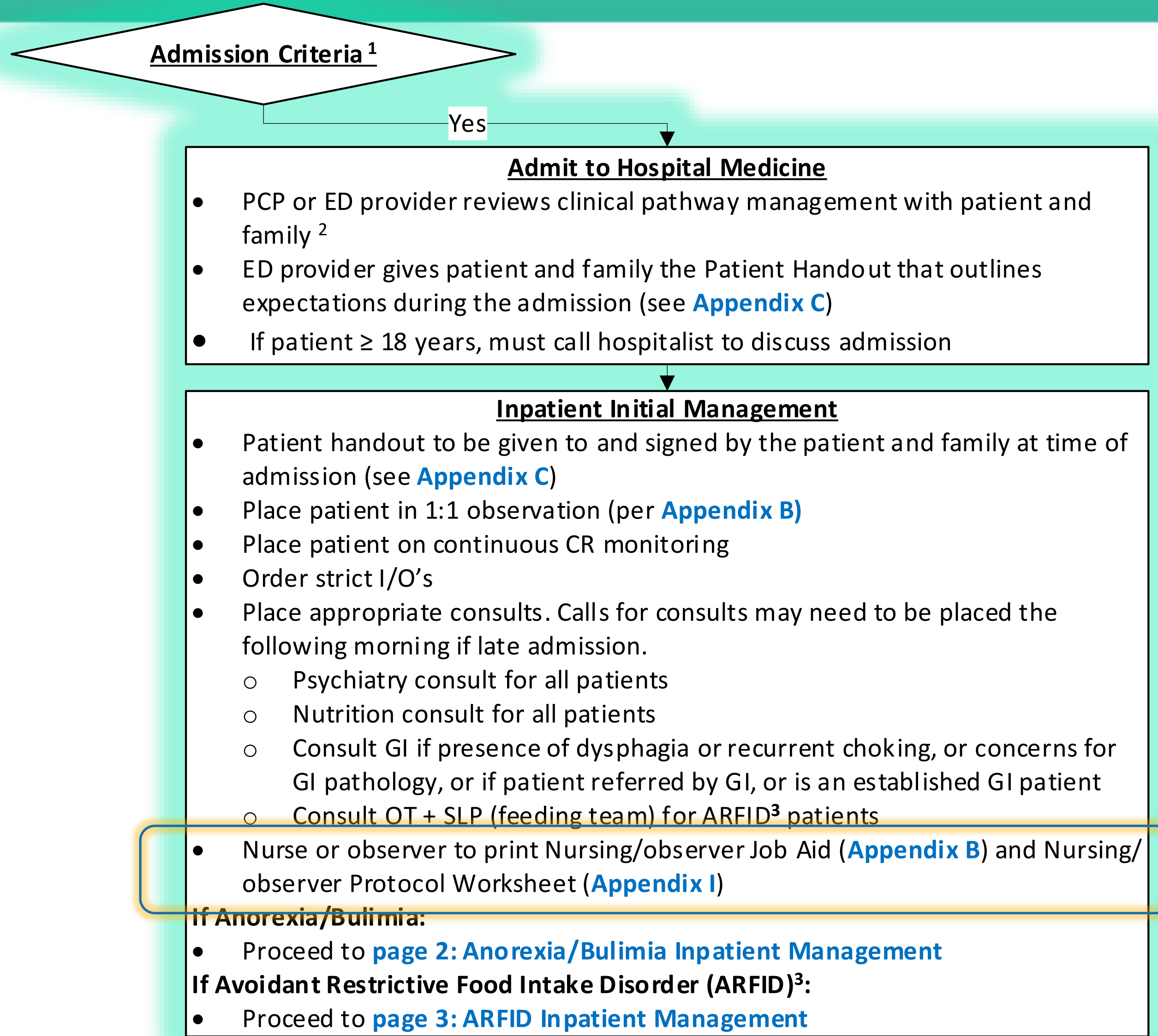
NEXT PAGE

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.



Vital Signs: q4hr

Orthostatic vital signs ("Orthostatics") HR and BP when supine and standing:

- Obtain 1st set on admission
- BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- If Orthostatic by BP or HR, take daily until normalized

Lowest heart rate per shift

- PCA document the lowest HR noted each shift in the vital signs flowsheet in Epic

Weight:

- Weigh patient every morning after 1st void and before breakfast
- Weigh patient in hospital gown only (no socks, underwear etc.)
- Do not share weight or BMI with patient or guardian (can share trend with guardian). Upon discharge, can share weight info with parent/guardian. Admission weight is defined as weight taken on first morning of pathway
- In general, goal weight gain is approximately 0.2 kg/day or 3 pounds per week

Nutrition and Fluids:

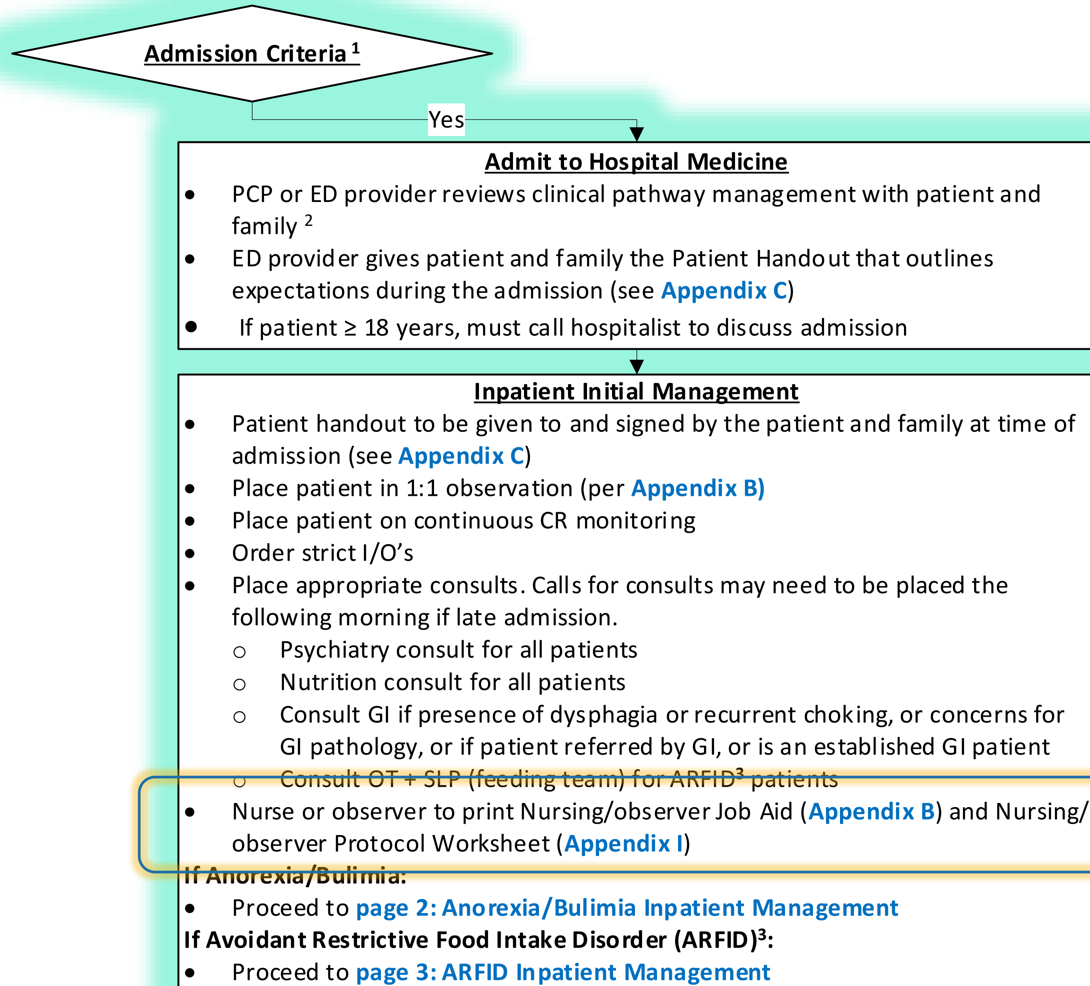
- See Appendix C (Patient Handout) for detailed Meal Guidelines. See Appendix D for Anorexia and Bulimia meal plan, & Appendix E for Avoidant Restrictive Food Intake Disorder (ARFID) meal plan
- Patients will be started on 1800 calories and advanced daily until they achieve consistent weight gain and are at activity level 5
- Each meal and snack will last 30 minutes
- Parents, guardians and visitors should not be present for meals and snacks until approved for meal support by the team
- Do not share calories with patient or family
- Staff must check tray for accuracy before each meal
- Staff remove meal ticket from tray, document meal completion on meal ticket, and save in the patient's thin chart for 48 hours
- Makeup oral nutrition supplement will be offered with/after snacks 3 times per day as needed if not 100% compliant with preceding meal and current snack
- NG tube will be placed after each snack if not 100% compliant with food + makeup and then removed
- NG tube exceptions
  - Consider not placing NG right away in patients <11 years
  - Consider not removing if NG tube is needed twice or more regardless of age

Nutrition Observation status: Nutrition observation is different than safety risk observation due to risk of harm to self or others. An eating disorder patient will have 2 observation orders, one for nutrition and one for safety risk.

- Definitions:
  - Nutrition observation is specific to patients with eating disorders and for observing meals to document intake, observing for eating disorder behaviors including hiding food or manipulating NG tube, and to provide support during and after meals and snacks.
  - Safety risk observation is for patients at risk of harm to self or others and is ordered using the safety risk order.

RETURN TO THE BEGINNING

©2019 Connecticut Children's Medical Center. All rights reserved.



Appendix I: Observation Worksheet

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Patient Name: Date: Unit:

Date	Day	Meal Step Plan	100% Compliance	Activity Level (Assigned)	Distraction techniques that work for the patient	Comments Eating behaviors/exercise/other
	Admit		Yes / No			
	1		Yes / No			
	2		Yes / No			
	3		Yes / No			
	4		Yes / No			
	5		Yes / No			
	6		Yes / No			
	7		Yes / No			
	8		Yes / No			

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.

If the patient has more classic anorexia or bulimia symptoms, proceed to page 2 for the Anorexia/Bulimia arm of the pathway

Yes

Admit to Hospital Medicine

- PCP or ED provider reviews clinical pathway management with patient and family [2]
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient ≥ 18 years, must call hospitalist to discuss admission

Inpatient Initial Management

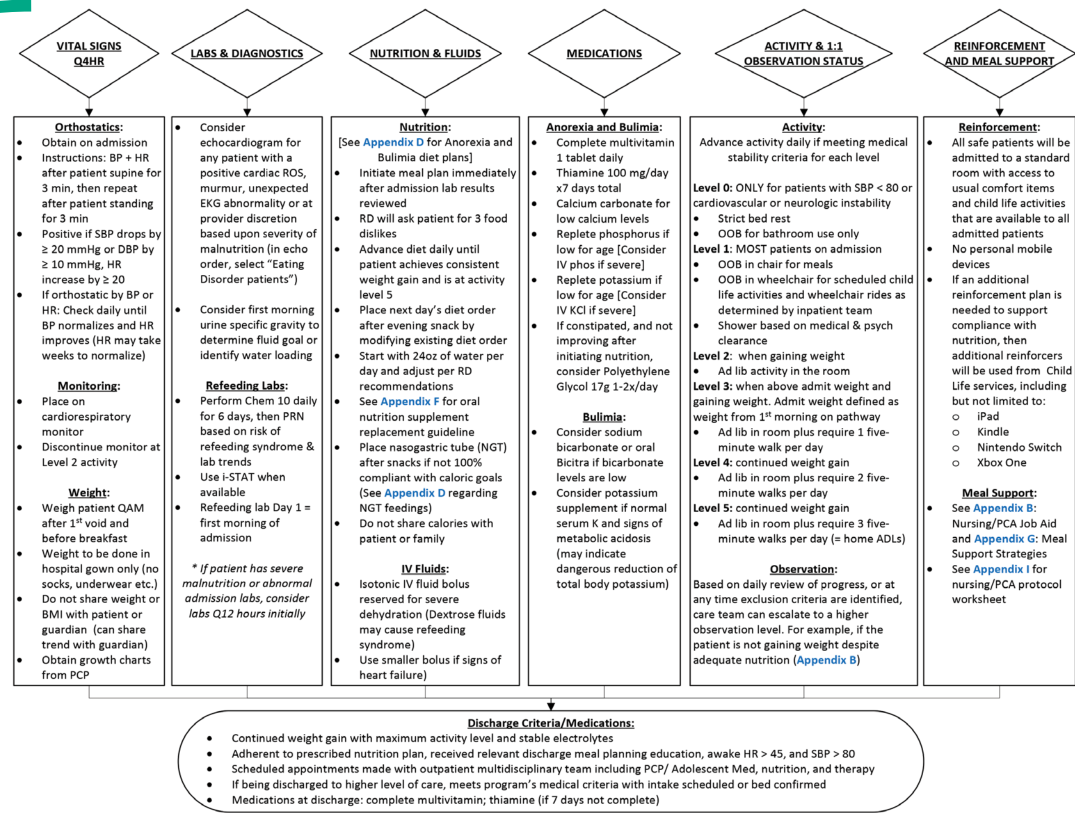
- Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)
- Place patient in 1:1 observation (per Appendix B)
- Place patient on continuous CR monitoring
- Order strict I/O's
- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
  - Psychiatry consult for all patients
  - Nutrition consult for all patients
  - Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI, or is an established GI patient
  - Consult OT + SLP (feeding team) for ARFID[3] patients
- Nurse or observer to print Nursing/observer Job Aid (Appendix B) and Nursing/observer Protocol Worksheet (Appendix I)

If Anorexia/Bulimia:

- Proceed to page 2: Anorexia/Bulimia Inpatient Management

If Avoidant Restrictive Food Intake Disorder (ARFID)[3]:

- Proceed to page 3: ARFID Inpatient Management


CLINICAL PATHWAY:
Eating Disorder
Anorexia/Bulimia Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

VITAL SIGNS Q4HR

Orthostatics:
- Obtain on admission
- Instructions: BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- Positive if SBP drops by ≥ 20 mmHg or DBP by ≥ 10 mmHg, HR increase by ≥ 20
- If orthostatic by BP or HR: Check daily until BP normalizes and HR improves (HR may take weeks to normalize)

Monitoring:
- Place on cardiorespiratory monitor
- Discontinue monitor at Level 2 activity

Weight:
- Weigh patient QAM after 1st void and before breakfast
- Weight to be done in hospital gown only (no socks, underwear etc.)
- Do not share weight or BMI with patient or guardian (can share trend with guardian)
- Obtain growth charts from PCP

LABS & DIAGNOSTICS

- Consider echocardiogram for any patient with a positive cardiac ROS, murmur, unexpected EKG abnormality or at provider discretion based upon severity of malnutrition (in echo order, select "Eating Disorder patients")
- Consider first morning urine specific gravity to determine fluid goal or identify water loading

Refeeding Labs:
- Perform Chem 10 daily for 6 days, then PRN based on risk of refeeding syndrome & lab trends
- Use i-STAT when available
- Refeeding lab Day 1 = first morning of admission

** If patient has severe malnutrition or abnormal admission labs, consider labs Q12 hours initially*

NUTRITION & FLUIDS

Nutrition:
[See Appendix D for Anorexia and Bulimia diet plans]
- Initiate meal plan immediately after admission lab results reviewed
- RD will ask patient for 3 food dislikes
- Advance diet daily until patient achieves consistent weight gain and is at activity level 5
- Place next day's diet order after evening snack by modifying existing diet order
- Start with 24oz of water per day and adjust per RD recommendations
- See Appendix F for oral nutrition supplement replacement guideline
- Place nasogastric tube (NGT) after snacks if not 100% compliant with caloric goals (See Appendix D regarding NGT feedings)
- Do not share calories with patient or family

IV Fluids:
- Isotonic IV fluid bolus reserved for severe dehydration (Dextrose fluids may cause refeeding syndrome)
- Use smaller bolus if signs of heart failure)

MEDICATIONS

Anorexia and Bulimia:
- Complete multivitamin 1 tablet daily
- Thiamine 100 mg/day x7 days total
- Calcium carbonate for low calcium levels
- Replete phosphorus if low for age [Consider IV phos if severe]
- Replete potassium if low for age [Consider IV KCl if severe]
- If constipated, and not improving after initiating nutrition, consider Polyethylene Glycol 17g 1-2x/day

Bulimia:
- Consider sodium bicarbonate or oral Bicitra if bicarbonate levels are low
- Consider potassium supplement if normal serum K and signs of metabolic acidosis (may indicate dangerous reduction of total body potassium)

ACTIVITY & 1:1 OBSERVATION STATUS

Activity:
Advance activity daily if meeting medical stability criteria for each level

Level 0: ONLY for patients with SBP < 80 or cardiovascular or neurologic instability
- Strict bed rest
- OOB for bathroom use only

Level 1: MOST patients on admission
- OOB in chair for meals
- OOB in wheelchair for scheduled child life activities and wheelchair rides as determined by inpatient team
- Shower based on medical & psych clearance

Level 2: when gaining weight
- Ad lib activity in the room

Level 3: when above admit weight and gaining weight. Admit weight defined as weight from 1st morning on pathway
- Ad lib in room plus require 1 five-minute walk per day

Level 4: continued weight gain
- Ad lib in room plus require 2 five-minute walks per day

Level 5: continued weight gain
- Ad lib in room plus require 3 five-minute walks per day (= home ADLs)

Observation:
Based on daily review of progress, or at any time exclusion criteria are identified, care team can escalate to a higher observation level. For example, if the patient is not gaining weight despite adequate nutrition (Appendix B)

REINFORCEMENT AND MEAL SUPPORT

Reinforcement:
- All safe patients will be admitted to a standard room with access to usual comfort items and child life activities that are available to all admitted patients
- No personal mobile devices
- If an additional reinforcement plan is needed to support compliance with nutrition, then additional reinforcers will be used from Child Life services, including but not limited to:
  - iPad
  - Kindle
  - Nintendo Switch
  - Xbox One

Meal Support:
- See Appendix B: Nursing/PCA Job Aid and Appendix G: Meal Support Strategies
- See Appendix I for nursing/PCA protocol worksheet

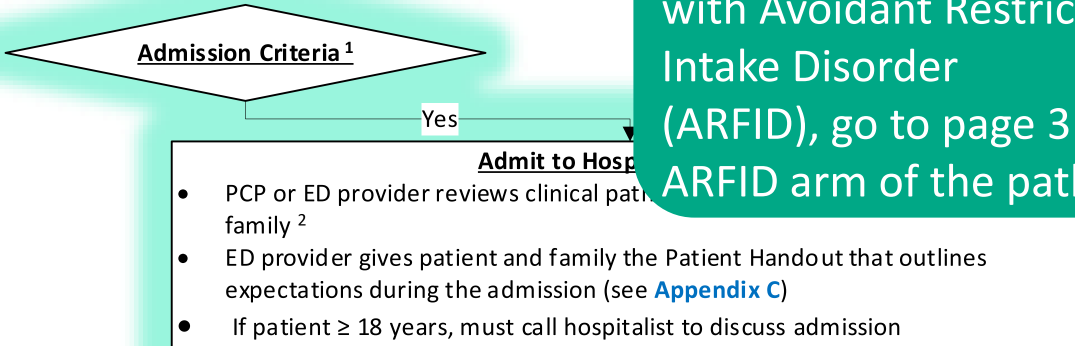
Discharge Criteria/Medications:
- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

RETURN TO THE BEGINNING

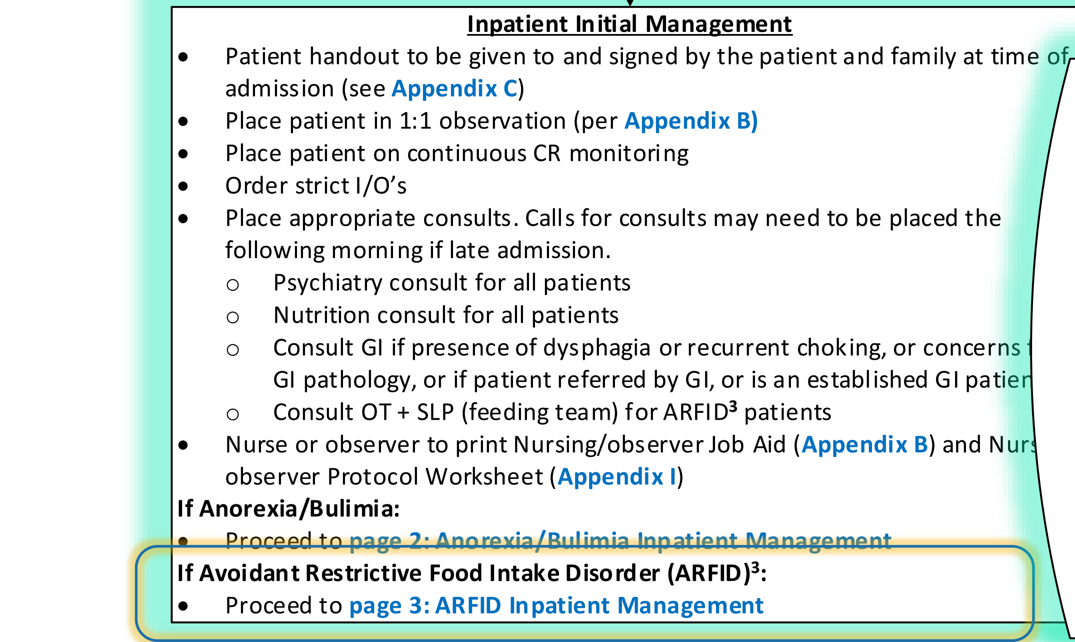
CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.



However, if the patient’s symptoms are more consistent with Avoidant Restrictive Food Intake Disorder (ARFID), go to page 3 for the ARFID arm of the pathway



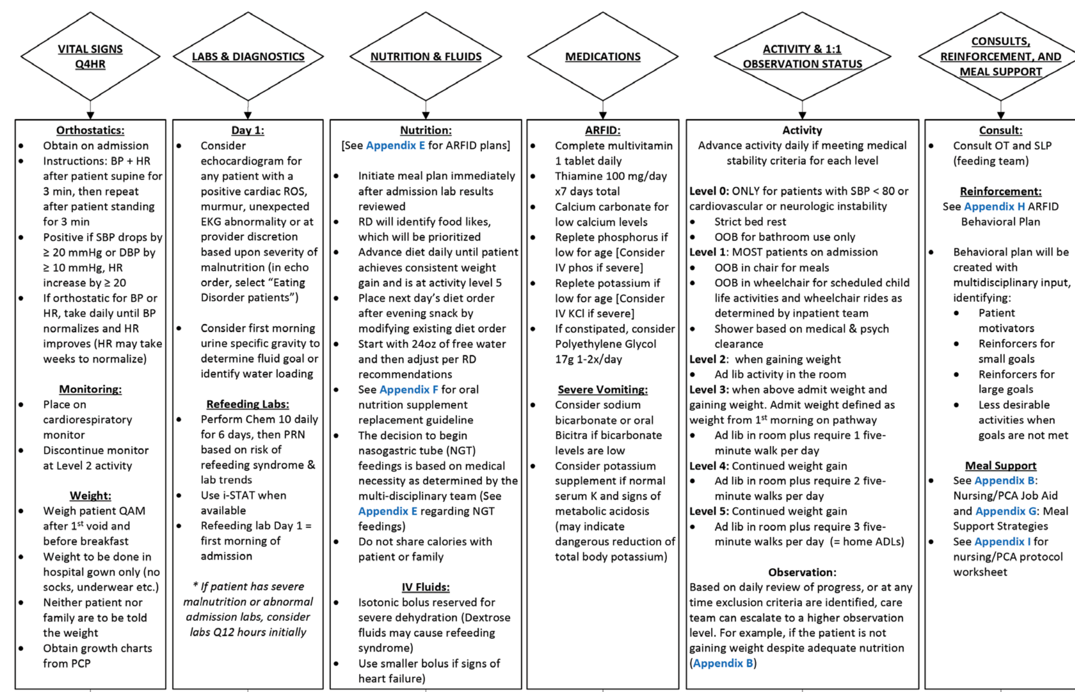
[3] **Avoidant Restrictive Food Intake Disorder (ARFID) Definition:**

Disordered eating due to one of the following:

- Concern about unpleasant consequences of eating, such as pain, vomiting, choking
- Avoidance based on sensory qualities
- Seeming lack of interest in eating or food

CLINICAL PATHWAY:
Eating Disorder
ARFID Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.



Discharge Criteria/Medications:

- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program’s medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

RETURN TO THE BEGINNING

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

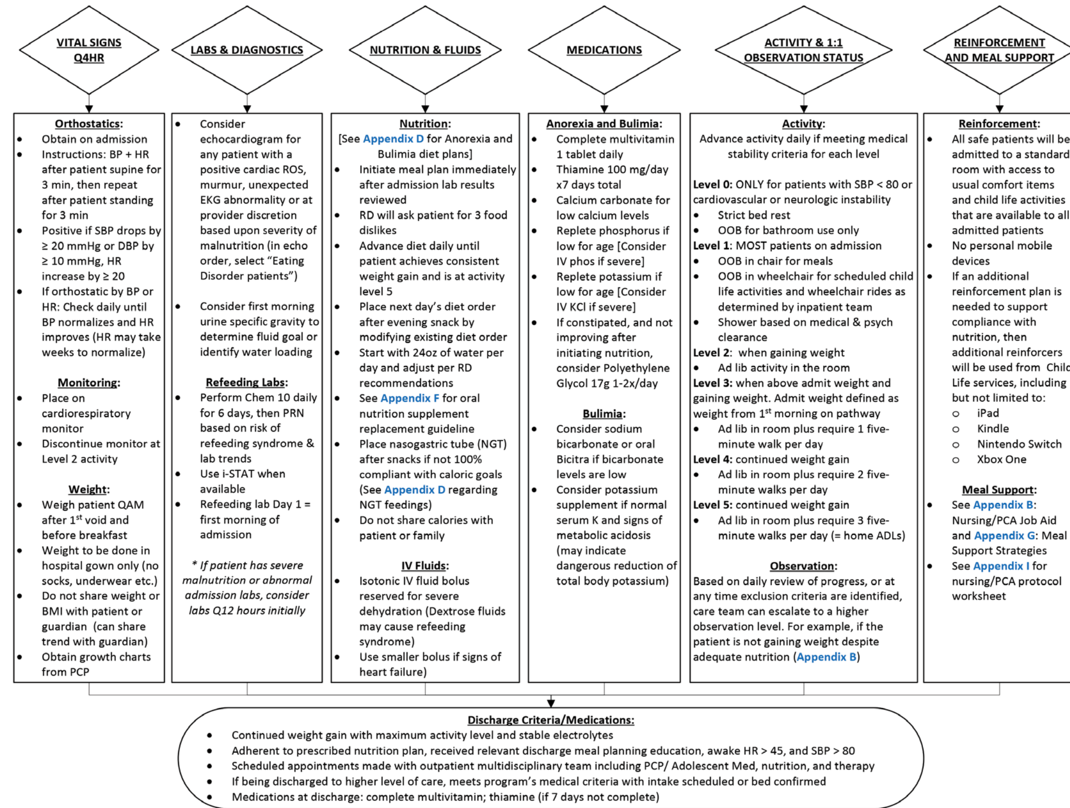
Connecticut Children's

©2019 Connecticut Children’s Medical Center. All rights reserved.

CLINICAL PATHWAY:
Eating Disorder
Anorexia/Bulimia Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

We will start with reviewing the Anorexia and Bulimia arm of the pathway.



RETURN TO THE BEGINNING

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Orthostatics

- Instructions for how to obtain orthostatics and when to discontinue

Monitoring

- Place on monitor
- Discontinue monitor when at Level 2 activity

Daily weights:

- Take in the morning after first void, and in hospital gown only
- Patient and family are NOT told the exact weight/BMI or the amount gained/lost
  - Guardian can be told the trend (up, down, same)

It is critical that weight, BMI, and calories of the diet are **not** shared with the patient and family

CLINICAL PATHWAY:
Eating Disorder
Anorexia/Bulimia Inpatient M

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

VITAL SIGNS Q4HR

Orthostatics:

- Obtain on admission
- Instructions: BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- Positive if SBP drops by ≥ 20 mmHg or DBP by ≥ 10 mmHg, HR increase by ≥ 20
- If orthostatic by BP or HR: Check daily until BP normalizes and HR improves (HR may take weeks to normalize)

Monitoring:

- Place on cardiorespiratory monitor
- Discontinue monitor at Level 2 activity

Weight:

- Weigh patient QAM after 1st void and before breakfast
- Weight to be done in hospital gown only (no socks, underwear etc.)
- Do not share weight or BMI with patient or guardian (can share trend with guardian)
- Obtain growth charts from PCP

LABS & DIAGNOSTICS

- Consider echocardiogram for any patient with a positive cardiac ROS murmur, unexpecte EKG abnormality or provider discretion based upon severity malnutrition (in ech order, select "Eating Disorder patients")
- Consider first morni urine specific gravit determine fluid goa identify water loadi

Refeeding Labs:

- Perform Chem 10 d for 6 days, then PRN based on risk of refeeding syndrome lab trends
- Use i-STAT when available
- Refeeding lab Day 1 first morning of admission

** If patient has severe malnutrition or abnorm admission labs, conside labs Q12 hours initiall*

NUTRITION & FLUIDS

MEDICATIONS

ACTIVITY & 1:1 OBSERVATION STATUS

Activity:
Advance activity daily if meeting medical stability criteria for each level

Level 0: ONLY for patients with SBP < 80 or cardiovascular or neurologic instability

- Strict bed rest
- OOB for bathroom use only

Level 1: MOST patients on admission

- OOB in chair for meals
- OOB in wheelchair for scheduled child life activities and wheelchair rides as determined by inpatient team
- Shower based on medical & psych clearance

Level 2: when gaining weight

- Ad lib activity in the room

Level 3: when above admit weight and gaining weight. Admit weight defined as weight from 1st morning on pathway

- Ad lib in room plus require 1 five-minute walk per day

Level 4: continued weight gain

- Ad lib in room plus require 2 five-minute walks per day

Level 5: continued weight gain

- Ad lib in room plus require 3 five-minute walks per day (= home ADLs)

Observation:
Based on daily review of progress, or at any time exclusion criteria are identified, care team can escalate to a higher observation level. For example, if the patient is not gaining weight despite adequate nutrition (Appendix B)

REINFORCEMENT AND MEAL SUPPORT

Reinforcement:

- All safe patients will be admitted to a standard room with access to usual comfort items and child life activities that are available to all admitted patients
- No personal mobile devices
- If an additional reinforcement plan is needed to support compliance with nutrition, then additional reinforcers will be used from Child Life services, including but not limited to:
  - iPad
  - Kindle
  - Nintendo Switch
  - Xbox One

Meal Support:

- See Appendix B: Nursing/PCA Job Aid and Appendix G: Meal Support Strategies
- See Appendix I for nursing/PCA protocol worksheet

VITAL SIGNS Q4HR

Orthostatics:

- Obtain on admission
- Instructions: BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- Positive if SBP drops by ≥ 20 mmHg or DBP by ≥ 10 mmHg, HR increase by ≥ 20
- If orthostatic by BP or HR: Check daily until BP normalizes and HR improves (HR may take weeks to normalize)

Monitoring:

- Place on cardiorespiratory monitor
- Discontinue monitor at Level 2 activity

Weight:

- Weigh patient QAM after 1st void and before breakfast
- Weight to be done in hospital gown only (no socks, underwear etc.)
- Do not share weight or BMI with patient or guardian (can share trend with guardian)
- Obtain growth charts from PCP

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

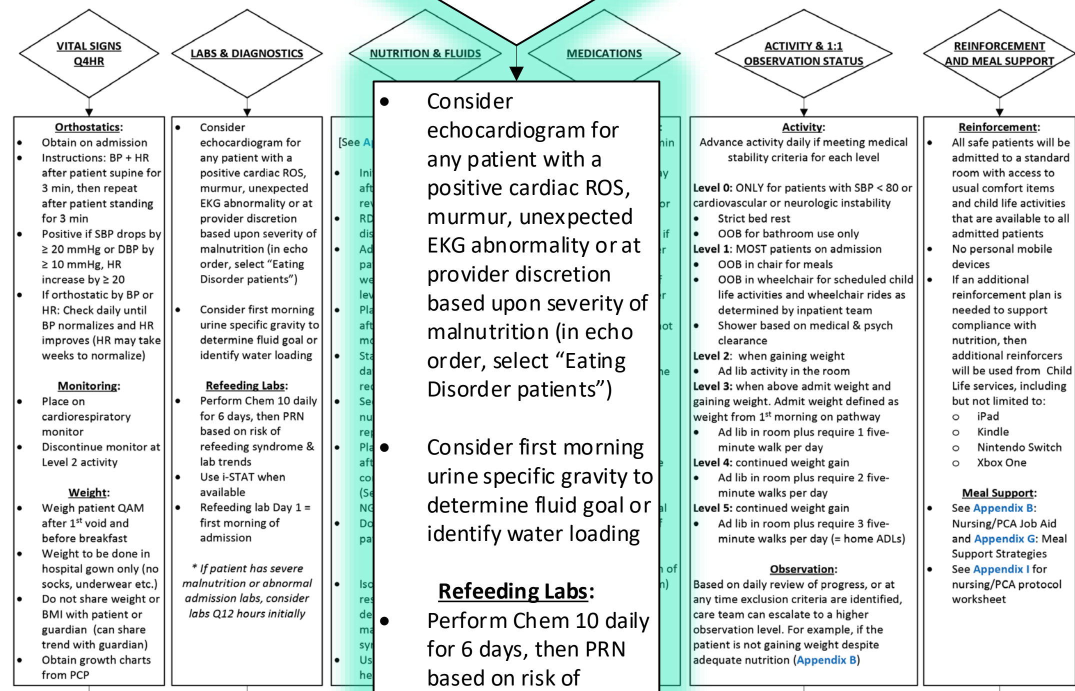
LAST UPDATED: 04.16.26

Connecticut Children's

©2019 Connecticut Children's Medical Center. All rights reserved.

Labs and Diagnostics:

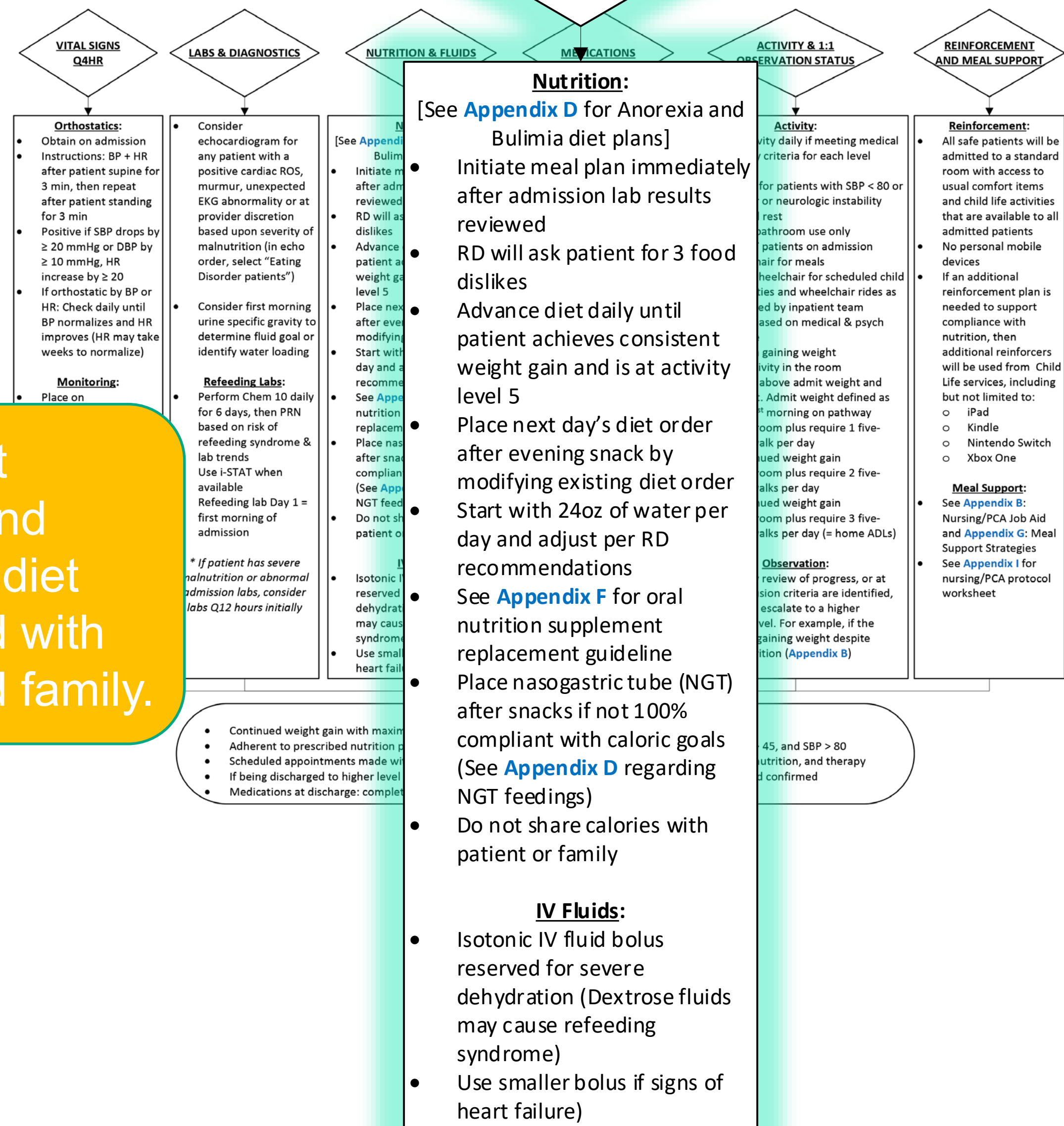
- Consider echocardiogram on any patient with a positive cardiac ROS, murmur, unexpected EKG abnormality, or at provider discretion based upon severity of malnutrition
- Consider urinalysis if concerns of dehydration or water loading
- Daily chemistry panels (Chem 10) to monitor for refeeding syndrome
  - On day 1 of the pathway, then daily for at least 5 more days, then PRN



Nutrition and Fluids:

- Start at Step 1- 1800 calories
- Advance diet daily until patient achieves consistent weight gain and is at activity level 5
- Place next day's diet order after evening snack by modifying existing diet order
- Start with 24oz of water per day and adjust per RD recs. Water is expected in daily meal compliance
- IV fluids are rarely needed, and dextrose can contribute to refeeding syndrome. Use small boluses if concern for heart failure

It is critical that weight, BMI, and calories of the diet are **not** shared with the patient and family.



CLINICAL PATHWAY:
Eating Disorder
Appendix D: Meal Plan for a Patient with Anorexia Nervosa or Bulimia Nervosa

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

- Increase nutrition daily until patient has consistent weight gain and is at activity level 5. The patient may not gain weight initially as starting calories are less than goal calories.
- Do not share calorie levels with patient or family.
- The meal plan consists of 3 meals and 3 snacks per day.
- The Registered Dietician (RD) will choose the meal plan to meet the patient's nutritional needs.
- Start with 24oz of water per day and adjust per RD recommendations.
- No additional coffee, tea, diet soda, artificial sweeteners or juice.
- If initial diet order is placed after 18:00, pathway nutrition to start the following day. Patient food from floor stock, a boxed lunch, or guardian chosen foods are acceptable options for evening meal and snack on the first day. These can be initiated and provided in the ED or upon arrival to the floor. PCA will document everything consumed in the Epic flowsheet.
- The patient will be allowed to choose 3 food dislikes, and will be told that the dislikes will be started on the following day.

- **Step One:** 1800 total calories per day
  Begins the first meal after admission through a minimum of 1 calendar day
- **Step Two:** 2100 total calories per day
- **Step Three:** 2400 total calories per day
- **Step Four:** 2700 total calories per day
- Additional steps increase by 300 calories per day

If a patient does not finish an entire meal or snack, they will have the opportunity to take in the missed calories at the snack by drinking the equivalent oral nutrition supplement (Refer to Appendix F; consult with Diet Tech if needed).

An NGT will be placed at the end of each snack time if the patient does not consume all the food and oral replacement for that snack and the prior meal. The remainder of the calories will be provided via the NGT. The NGT will then be removed when the infusion is completed. The patient will then be given a "fresh start" to be able to achieve 100% compliance with the next meal.

The decision to place an NGT in a patient < 11 years old will be determined by the multi-disciplinary team.

If a patient has needed an NGT more than twice, in consultation with psychiatry, consideration should be made to keep the NGT in place, particularly if there has been no progress in oral feeds after the NGT is pulled.

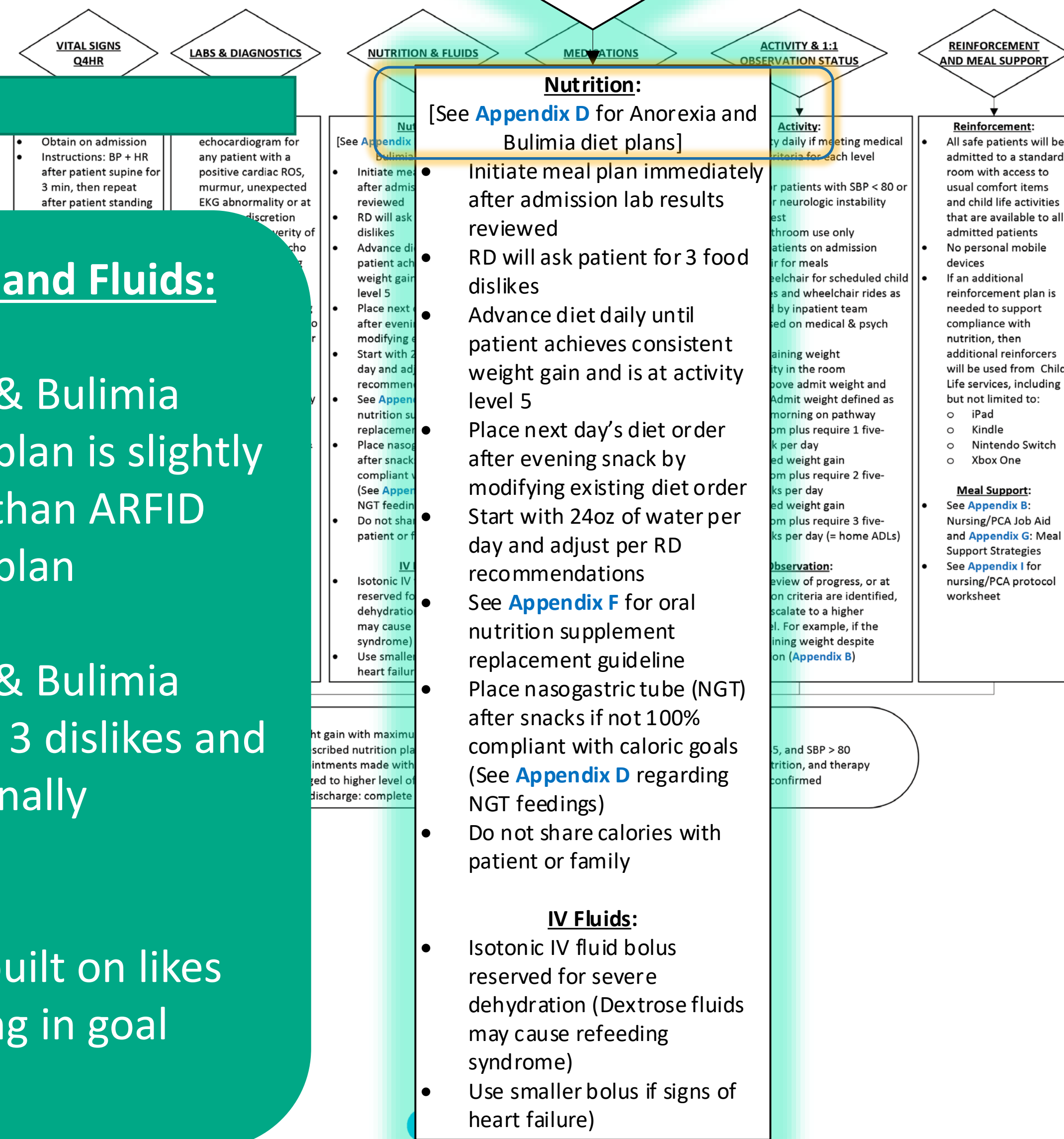
CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Nutrition and Fluids:

- Anorexia & Bulimia nutrition plan is slightly different than ARFID nutrition plan
- Anorexia & Bulimia allows for 3 dislikes and is nutritionally complete
- ARFID is built on likes and getting in goal calories



CLINICAL PATHWAY:
Eating Disorder
Appendix F: Oral Nutrition Supplement Replacement Guideline

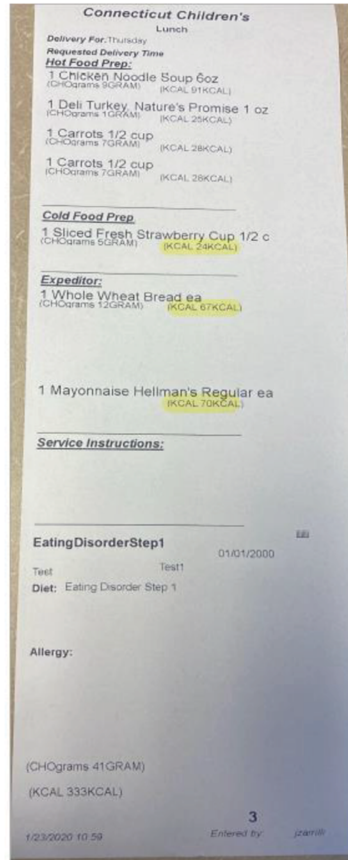
THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

- Refer to CBORD meal ticket for total and individual food calories for each meal and snack.
- For all food and beverage not consumed, calculate number of calories remaining on tray.
- For 30 kcal/oz supplement, give patient 1 ml per 1 calorie remaining on tray.
- For 45 kcal/oz supplement, give patient 1 ml per 1.5 calories remaining on tray.
- Please save all meal and snack tickets in patient's thin chart.

Example:

Patient ate all their chicken noodle soup, turkey, and carrots, but they only ate ½ their portion of strawberries and they did not eat their bread or mayonnaise. How much oral nutrition supplement will they need to replace the food they did not eat?

- Step 1: Use the ticket to calculate number of calories patient did not eat.
  - ½ strawberries = 12 kcal
  - Bread = 67 kcal
  - Mayonnaise = 70 kcal
  - Total = 12 + 67 + 70 = 149 kcal
- Step 2:
  - If patient is getting 30 cal/oz supplement (1 kcal = 1 ml supplement) Convert to ml of supplement
    - 149 calories = 149 ml of supplement
  - If patient is getting 45 cal/oz supplement (1.5 kcal = 1ml of supplement)
    Convert to ml of supplement
    - $\frac{149 \text{ kcal}}{1.5 \text{ kcal/ml}} = 99.3$ ml


Connecticut Children's
Lunch
Delivery For: Thursday
Requested Delivery Time
Hot Food Prep:
1 Chicken Noodle Soup 6oz (CHOgrams 9GRAM) (KCAL 91KCAL)
1 Deli Turkey, Nature's Promise 1 oz (CHOgrams 1GRAM) (KCAL 25KCAL)
1 Carrots 1/2 cup (CHOgrams 7GRAM) (KCAL 28KCAL)
1 Carrots 1/2 cup (CHOgrams 7GRAM) (KCAL 28KCAL)
Cold Food Prep
1 Sliced Fresh Strawberry Cup 1/2 c (CHOgrams 5GRAM) (KCAL 24KCAL)
Expeditor:
1 Whole Wheat Bread ea (CHOgrams 12GRAM) (KCAL 67KCAL)
1 Mayonnaise Hellman's Regular ea (KCAL 70KCAL)
Service Instructions:
EatingDisorderStep1 01/01/2000
Test Test1
Diet: Eating Disorder Step 1
Allergy:
(CHOgrams 41GRAM)
(KCAL 333KCAL)
3
1/23/2020 10:59 Entered by:

RETURN TO THE BEGINNING

©2019 Connecticut Children's Medical Center. All rights reserved.

CLINICAL PATHWAY:
Eating Disorder ... Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

NUTRITION & FLUIDS

VITAL SIGNS Q4HR | LABS & DIAGNOSTICS | NUTRITION & FLUIDS | MEDICATIONS | ACTIVITY & 1:1 OBSERVATION STATUS | REINFORCEMENT AND MEAL SUPPORT

Nutrition:

[See **Appendix D** for Anorexia and Bulimia diet plans]

- Initiate meal plan immediately after admission lab results reviewed
- RD will ask patient for 3 food dislikes
- Advance diet daily until patient achieves consistent weight gain and is at activity level 5
- Place next day's diet order after evening snack by modifying existing diet order
- Start with 24oz of water per day and adjust per RD recommendations
- See **Appendix F** for oral nutrition supplement replacement guideline
- Place nasogastric tube (NGT) after snacks if not 100% compliant with caloric goals (See **Appendix D** regarding NGT feedings)
- Do not share calories with patient or family

IV Fluids:

- Isotonic IV fluid bolus reserved for severe dehydration (Dextrose fluids may cause refeeding syndrome)
- Use smaller bolus if signs of heart failure)

Meal Replacement:

- If patient does not finish an entire meal and the following snack, missed calories should be offered at the end of snack in the form of liquid nutrition supplement (offer up to 3 times per day)
  - See appendix F for how to calculate the amount of Ensure replacement based on food not eaten (see 30 vs. 45 cal/oz)

RETURN TO THE BEGINNING

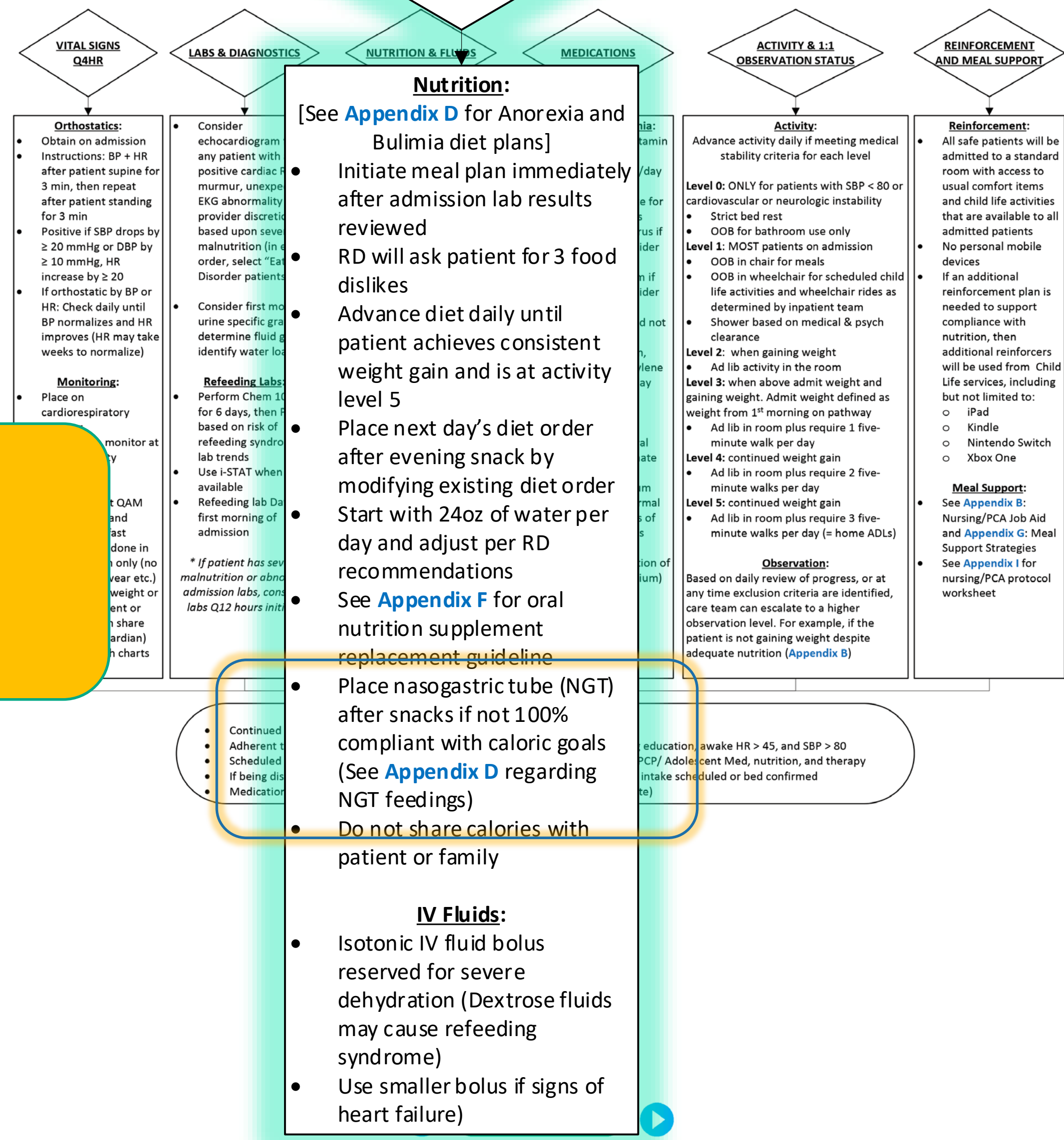
CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD
LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Nasogastric Tube (NGT) Placement:

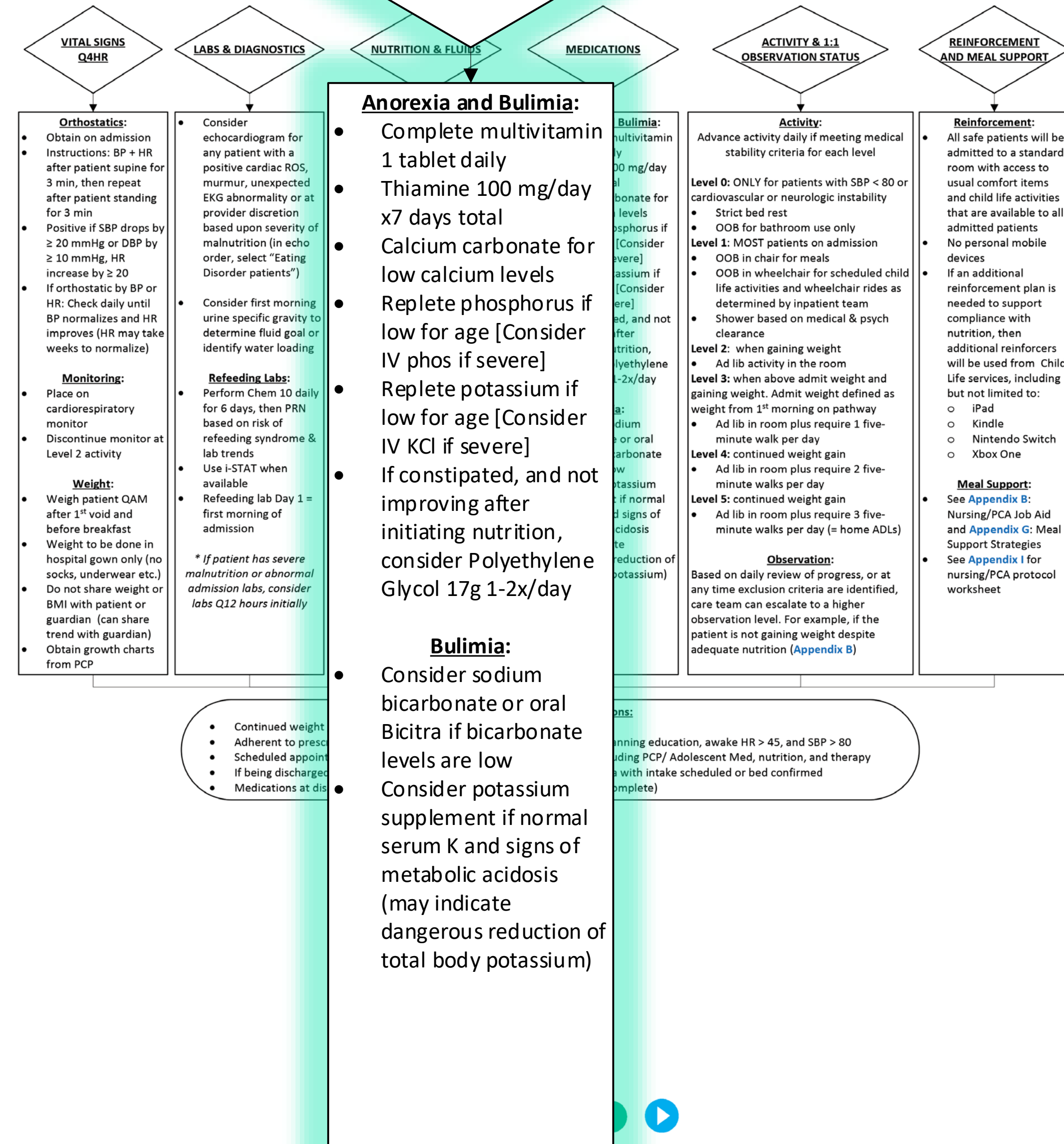
- If medically necessary, place NGT after snack if patient did not complete 100% of food and ensure replacement for the meal & snack (assess 3 times per day)
- Remove the NGT immediately after the NGT Infusion is completed
- For patients <11 years, the decision to place an NGT should include discussion with the multidisciplinary team (Refer to appendix D)
- If a patient has needed an NGT more than twice, in consultation with psychiatry, consider keeping the NGT in place, particularly if there has been no progress in oral feeds after the NGT is pulled

It is critical that calories are **not** shared with the patient and family.



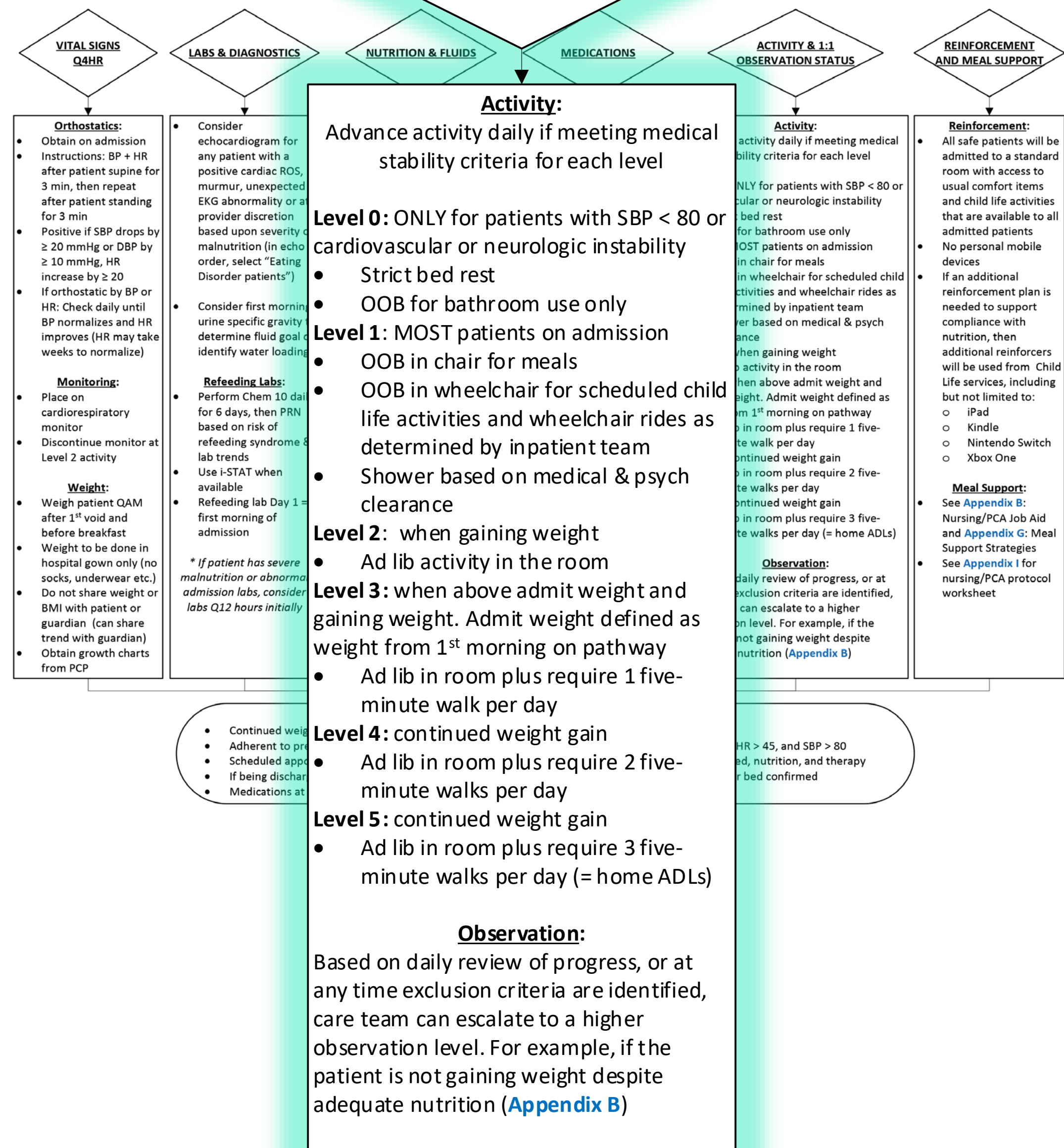
Medications:

- All patients with Anorexia Nervosa/Bulimia need:
  - Complete multivitamin
  - Thiamine
- Additional vitamins and electrolytes vary based on lab results and underlying nutritional deficiencies
- If constipated, and not improving after initiating nutrition, consider Polyethylene Glycol 17g 1-2x/day



Activity Status:

- Most patients are initially place on step 1 activity which is mostly in bed but requires OOB for meals in a chair
- Activity level 0, strict bedrest, is reserved for patients with SBP < 80 or cardiovascular or neurologic instability
- Activity level is advanced daily if medical stability criteria are met (vital signs and weight) to goal of activity level 5



Anorexia nervosa patients have restricted caloric intake relative to energy expenditure that leads to weight loss, plus either an intense fear of gaining weight, or behaviors that consistently interfere with weight gain like over-exercising. Also, there is an altered perception of body weight or shape, or lack of acknowledgment of the seriousness of one's low body weight.

Individuals with ARFID usually do not have altered body image perceptions. They limit/restrict food intake for one of the following reasons:

1. Concern about unpleasant consequences of eating, such as pain, vomiting or choking
2. Based on sensory qualities of the food
3. Seeming lack of interest in eating or food

During this hospitalization, meal time support will be developed by the medical team and then provided by sitter. Meal support strategies will be taught to the family, and meal support may be transitioned to family members to practice before discharge from the hospital.

The goal of meal time support is to help with extinction of the learned avoidance behaviors, increase comfort during meal time, and increase the amount of food consumed during meal.

Learned "safety or avoidance behaviors"

- Eating the same limited foods - can increase sensitivities to new tastes, textures or smells.
- Eating the same foods over and over - can become boring and further limit options.
- Nibbling at food, taking very small bites, or excessive chewing.
- Avoiding eating – can increase the worry and anxiety associated with eating.

Establish routines - Keep TRYING! This takes practice and consistent exposure

- Structured meal place: sit in chair at table. Activities should be put away during meals.
- Structured meal time and duration: Keep to schedule and remove meal after 30 minutes.

Social Modeling

- Eat together – observer is required to sit in the room, consider sitting at the table based on patient comfort. If family is providing meal support, they can sit at the table.
- Watch your own body language and facial expressions- try to convey positive feelings about food, model expected feeding behavior.
- Do not over focus on the child's behavior - offer praise for interactions with food. Otherwise remain neutral about the patient's eating. Do not punish the patient.
- Validate the patient's feelings– Let them know all emotions/feelings are acceptable.

Think about your words

- Try to use "you can" versus "can you?"
- Offer choices: "Which would you like to start with? The apples or the crackers?"
- Acknowledge: "WOW, you worked hard, that wasn't easy, and you were able to take a nice sized bite of that sandwich" AVOID: "I knew you'd like it" OR "See, it was easy"
- It is generally best to avoid talking about food

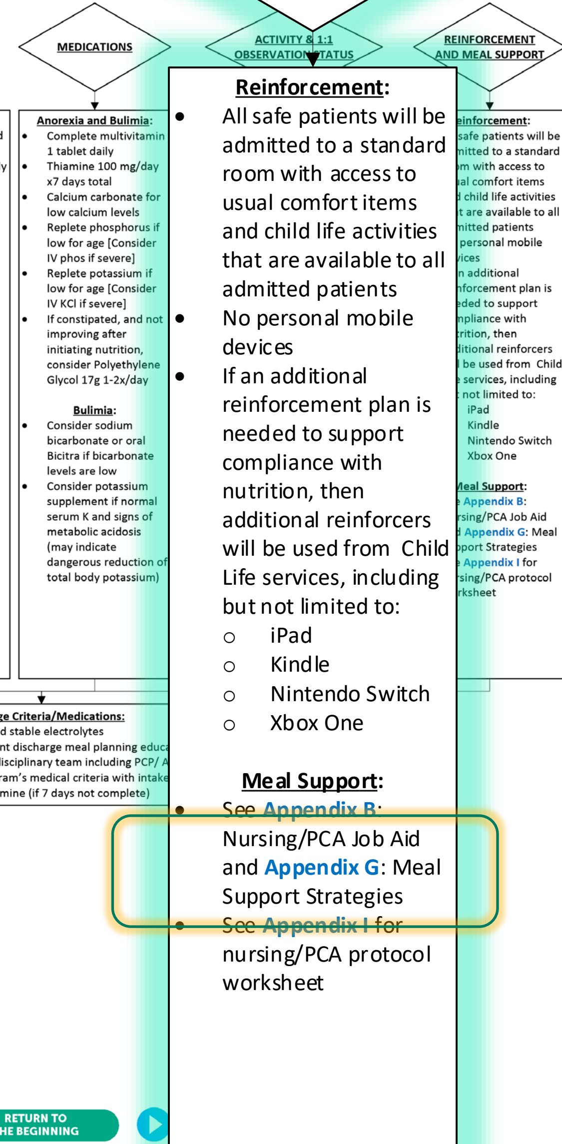
©2019 Connecticut Children's Medical Center. All rights reserved.

Reinforcement and Meal Support:

- Usual comfort items from home and standard child life activities are universally allowed.
- Personal mobile devices (such as cell phones) are never allowed. Laptops for school work may be allowed on a
- Meal Support strategies as outlined in Appendices B and G may be helpful to encourage nutritional compliance.
- Some children may benefit from additional tangible reinforcement items offered by Child Life.

CLINICAL PATHWAY:
Eating Disorder
Anorexia/Bulimia Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.



©2019 Connecticut Children's Medical Center. All rights reserved.

CLINICAL PATHWAY:
Eating Disorder
Anorexia/Bulimia Inpatient Management

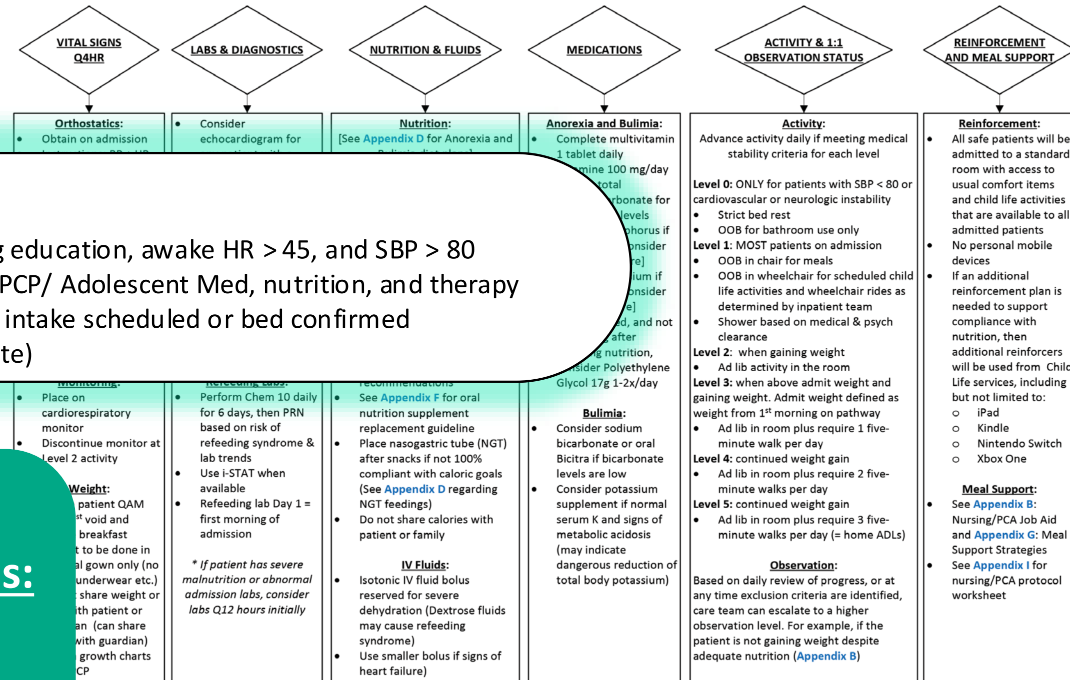
THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Discharge Criteria/Medications:

- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

Discharge Criteria/Medications:

Discharge criteria and home medications are outlined



Discharge Criteria/Medications:

- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

RETURN TO THE BEGINNING

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

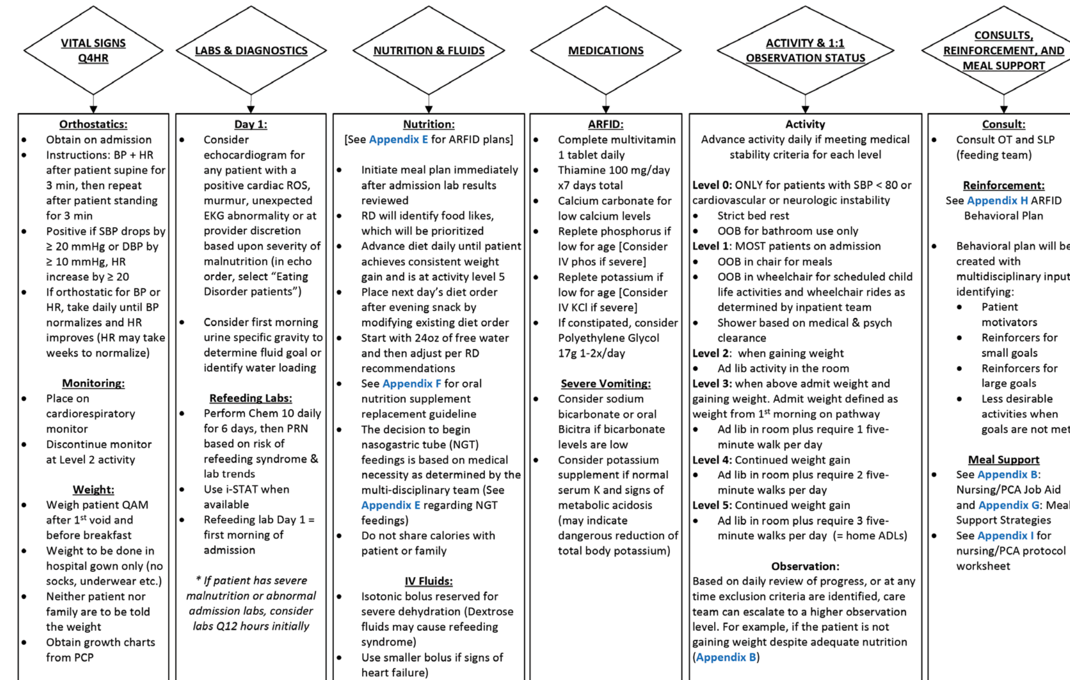
LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Page 3 of the pathway describes specific treatment goals for patients with ARFID

CLINICAL PATHWAY:
Eating Disorder
ARFID Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.



Discharge Criteria/Medications:

- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

RETURN TO THE BEGINNING

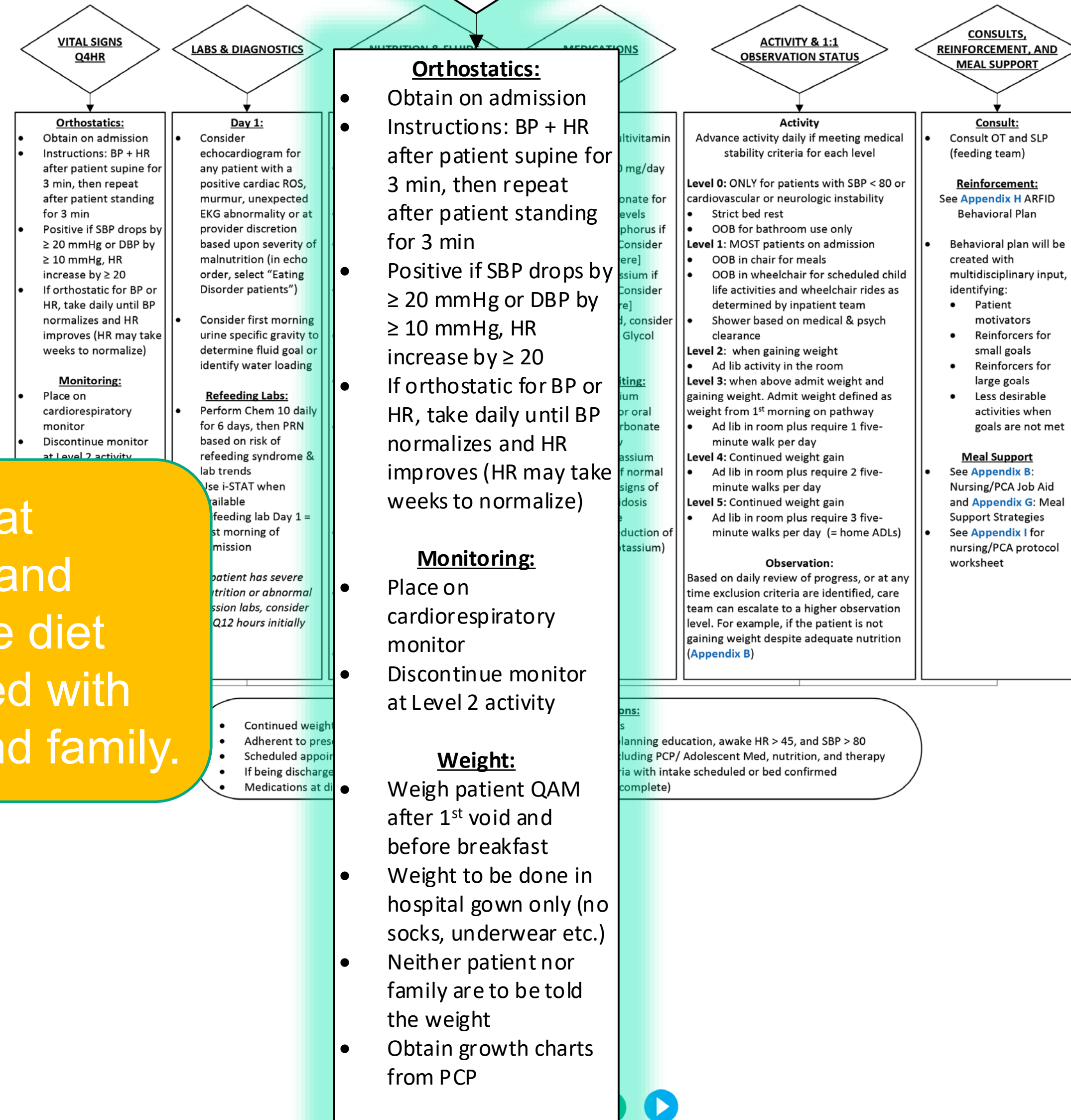
CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Daily weights, orthostatic vital signs, and monitoring are performed according to the same standards as for patients with anorexia or bulimia

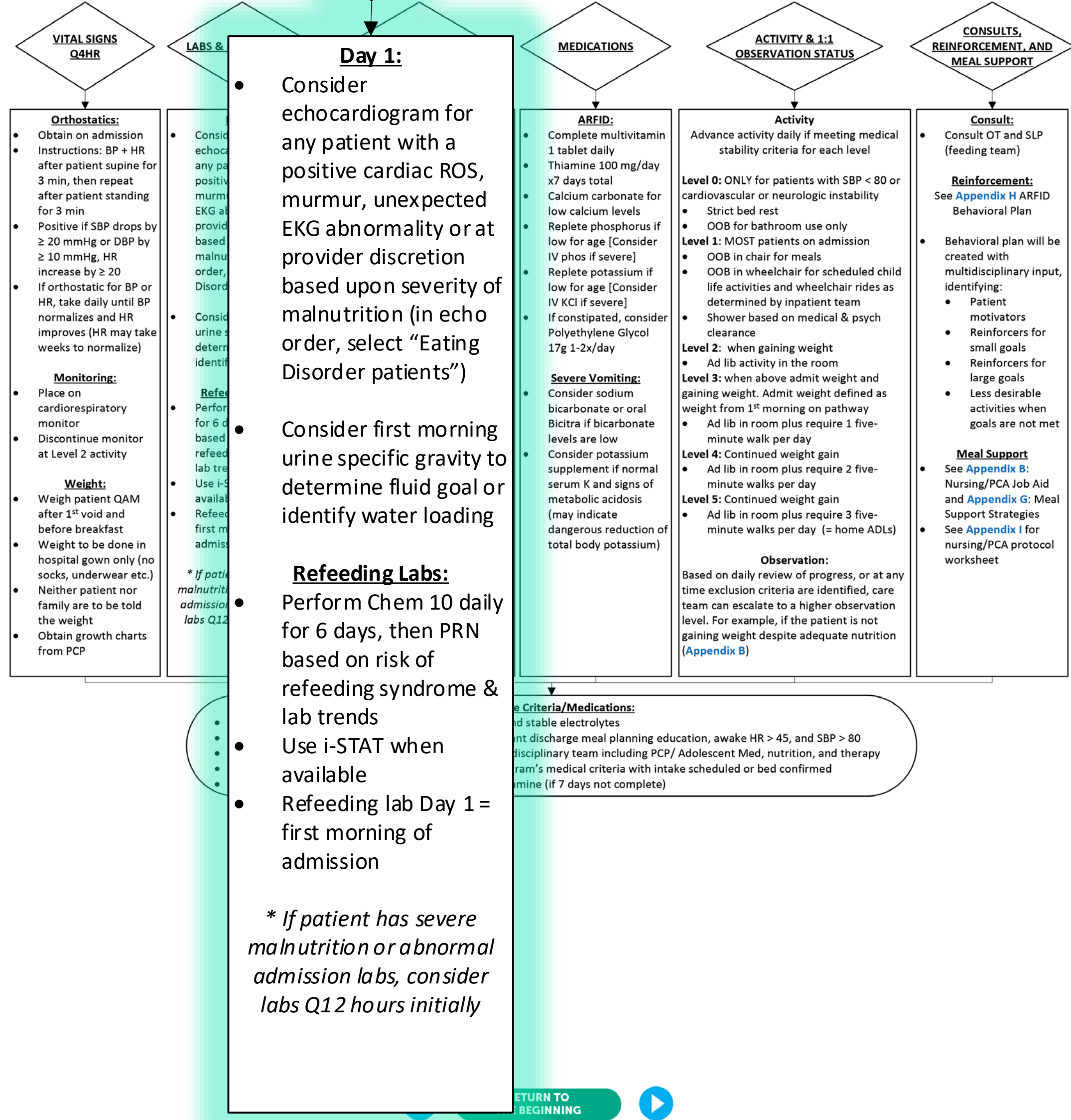
It is critical that weight, BMI, and calories of the diet are **not** shared with the patient and family.



©2019 Connecticut Children's Medical Center. All rights reserved.

Labs and Diagnostics:

- Same as for patients with anorexia or bulimia



The goal of the meal plan for the first day is to learn about the patient's food history, current and recent food likes, as well as reinforcers that will help engage the patient to eat.

The goal of the meal plan for the next 4 days is to prevent further weight loss and to encourage the patient to eat by mouth. The meals will include many likes and familiar foods. There will be less of a focus on nutritional balance.

Increase nutrition until patient has consistent weight gain and is at activity level 5.

Patients with ARFID will likely be on a behavioral plan using frequent reinforcers for goals such as smelling, touching, tasting and/or eating small bites or a percentage of the meal.

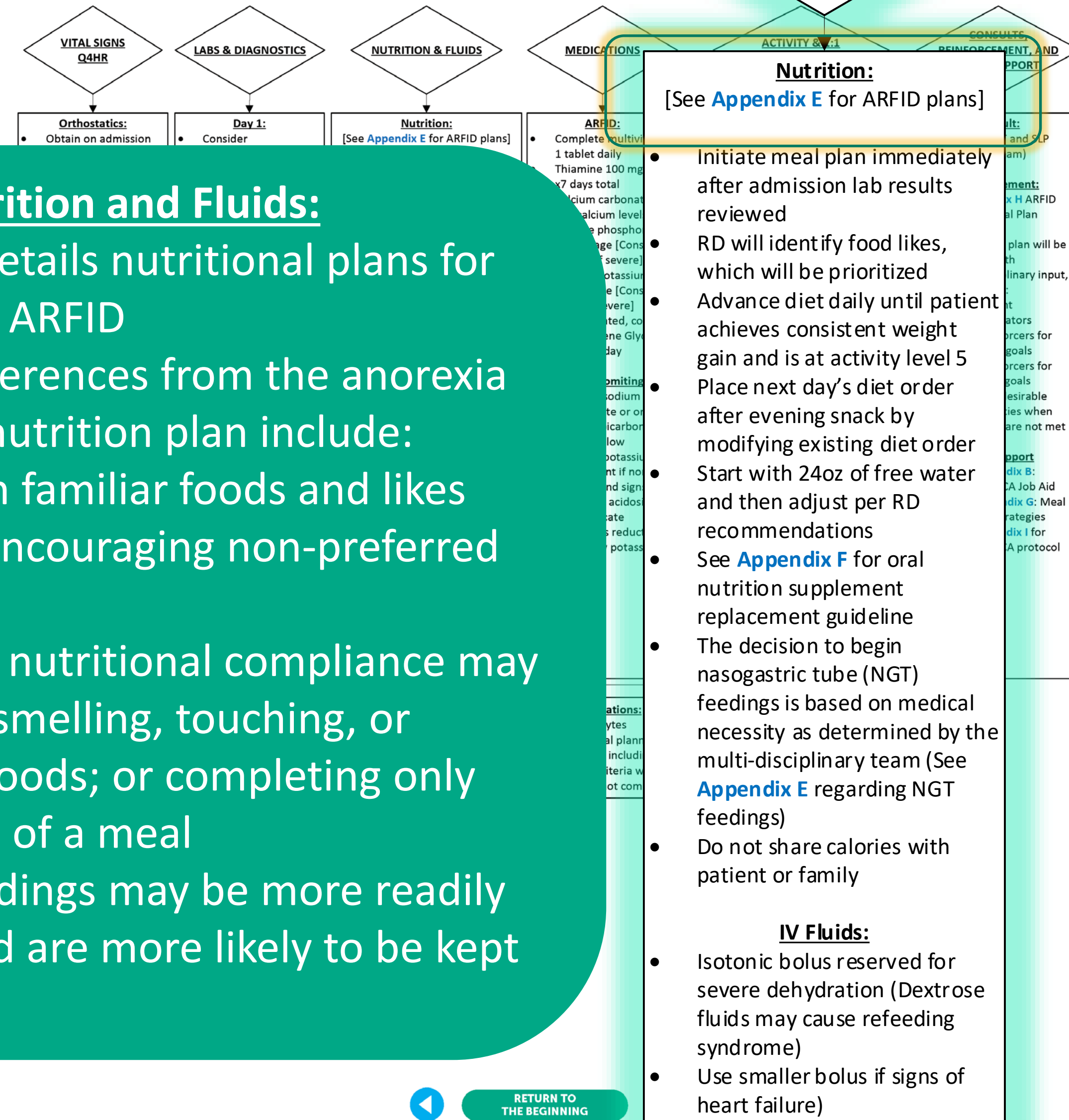
- The meal plan consists of 3 meals + 3 snacks.
- The Registered Dietician (RD) will choose the meal plan with a focus on likes and familiar foods.
- Start with 24oz of water per day and adjust per RD recommendations.
- If initial diet order is placed after 1800, pathway nutrition to start the following day. Patient food from floor stock, a boxed lunch, or guardian chosen foods are acceptable options for evening meals. These can be initiated and provided in the ED or upon arrival to the floor. PCA will document everything consumed in the EPIC flowsheet.
- A feeding team (OT and SLP) evaluation will be ordered on the first day.
- **Step One:** 1800 total calories per day
- **Step Two:** 2100 total calories per day
- **Step Three:** 2400 total calories per day
- **Step Four:** 2700 total calories per day
- Additional steps increase by 300 calories per day

If a patient does not finish an entire meal or snack, they will have the opportunity to take in the missed calories at the snack by drinking the equivalent oral nutrition supplement (Refer to Appendix F; consult with Diet Tech if needed).

Patients with ARFID are more likely to require nasogastric tube (NGT) feedings. The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team. Once an NGT is placed, the medical team will determine if the tube should be removed or left in place.

The decision to place an NGT in a patient < 11 years old will be determined by the multi-disciplinary team.

©2019 Connecticut Children's Medical Center. All rights reserved.



Nutrition and Fluids:

- Appendix E details nutritional plans for patients with ARFID
- The main differences from the anorexia and bulimia nutrition plan include:
  - Focus on familiar foods and likes before encouraging non-preferred food
  - Goals of nutritional compliance may include smelling, touching, or tasting foods; or completing only portions of a meal
  - NGT feedings may be more readily used and are more likely to be kept in place

©2019 Connecticut Children's Medical Center. All rights reserved.

The goal of the meal plan for the first day is to learn about the patient's food history, current and recent food likes, as well as reinforcers that will help engage the patient to eat.

The goal of the meal plan for the next 4 days is to prevent further weight loss and to encourage the patient to eat by mouth. The meals will include many likes and familiar foods. There will be less of a focus on nutritional balance.

Increase nutrition until patient has consistent weight gain and is at activity level 5.

Patients with ARFID will likely be on a behavioral plan using frequent reinforcers for goals such as smelling, touching, tasting and/or eating small bites or a percentage of the meal.

- The meal plan consists of 3 meals + 3 snacks.
- The Registered Dietician (RD) will choose the meal plan with a focus on likes and familiar foods.
- Start with 24oz of water per day and adjust per RD recommendations.
- If initial diet order is placed after 1800, pathway nutrition to start the following day. Patient food from floor stock, a boxed lunch, or guardian chosen foods are acceptable options for evening meals. These can be initiated and provided in the ED or upon arrival to the floor. PCA will document everything consumed in the EPIC flowsheet.
- A feeding team (OT and SLP) evaluation will be ordered on the first day.

- **Step One:** 1800 total calories per day
- **Step Two:** 2100 total calories per day
- **Step Three:** 2400 total calories per day
- **Step Four:** 2700 total calories per day
- Additional steps increase by 300 calories per day

If a patient does not finish an entire meal or snack, they will have the opportunity to take in the missed calories at the snack by drinking the equivalent oral nutrition supplement (Refer to Appendix F; consult with Diet Tech if needed).

Patients with ARFID are more likely to require nasogastric tube (NGT) feedings. The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team. Once an NGT is placed, the medical team will determine if the tube should be removed or left in place.

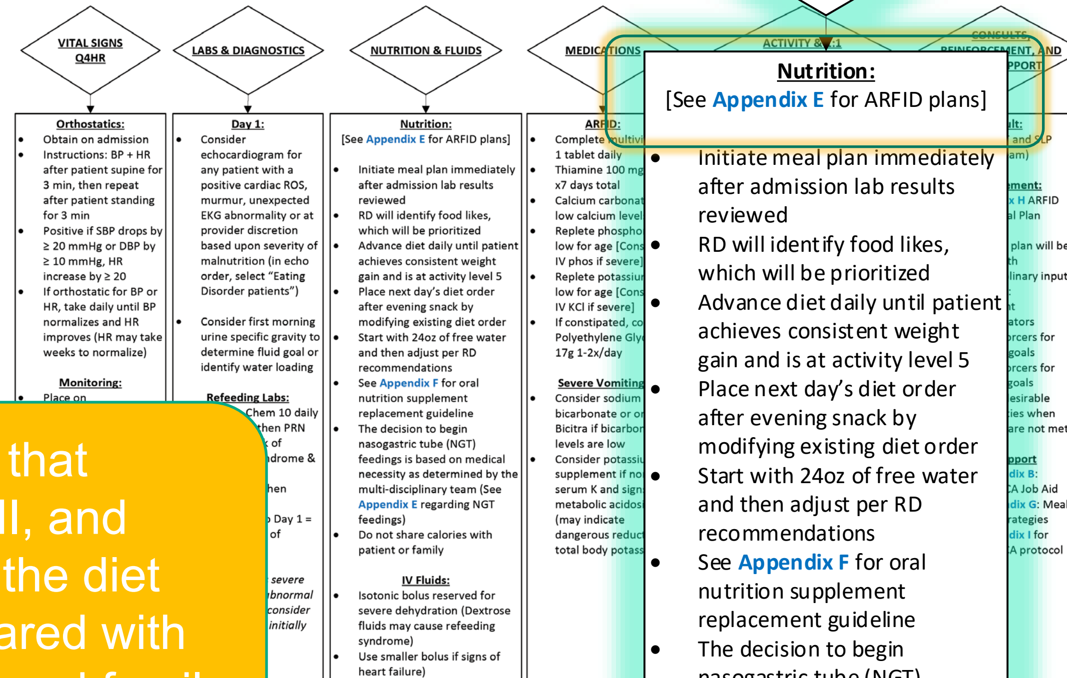
The decision to place an NGT in a patient < 11 years old will be determined by the multi-disciplinary team.

©2019 Connecticut Children's Medical Center. All rights reserved.

It is critical that weight, BMI, and calories of the diet are **not** shared with the patient and family.

CLINICAL PATHWAY:
Eating Disorder
ARFID Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.



CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Medications:

- All patients with ARFID also need:
  - Complete multivitamin
  - Thiamine
- May also vary based on lab results and underlying nutritional deficiencies.

CLINICAL PATHWAY:
Eating Disorder
ARFID Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

MEDICATIONS

VITAL SIGNS Q4HR | LABS & DIAGNOSTICS | NUTRITION & FLUIDS | MEDICATIONS | ACTIVITY & 1:1 OBSERVATION STATUS | CONSULTS, REINFORCEMENT, AND MEAL SUPPORT

Orthostatics:
- Obtain on admission
- Instructions: BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- Positive if SBP drops by ≥ 20 mmHg or DBP by ≥ 10 mmHg, HR increase by ≥ 20
- If orthostatic for BP or HR, take daily until BP normalizes and HR improves (HR may take weeks to normalize)

Monitoring:
- Place on cardiorespiratory monitor
- Discontinue monitor at Level 2 activity

Weight:
- Weigh patient QAM after 1st void and before breakfast
- Weight to be done in hospital gown only (no socks, underwear etc.)
- Neither patient nor family are to be told the weight
- Obtain growth charts from PCP

Day 1:
- Consider echocardiogram for any patient with a positive cardiac ROS, murmur, unexpected EKG abnormality or at provider discretion based upon severity of malnutrition (in echo order, select "Eating Disorder patients")
- Consider first morning urine specific gravity to determine fluid goal or identify water loading

Refeeding Labs:
- Perform Chem 10 daily for 6 days, then PRN based on risk of refeeding syndrome & lab trends
- Use i-STAT when available
- Refeeding lab Day 1 = first morning of admission

** If patient has severe malnutrition or abnormal admission labs, consider labs Q12 hours initially*

Nutrition:
[See Appendix E for ARFID plans]
- Initiate meal plan immediately after admission lab results reviewed
- RD will identify food likes, which will be prioritized
- Advance diet daily until patient achieves consistent weight gain and is at activity level 5
- Place next day's diet order after evening snack by modifying existing diet order
- Start with 24oz of free water and then adjust per RD recommendations
- See Appendix F for oral nutrition supplement replacement guideline
- The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team (See Appendix E regarding NGT feedings)
- Do not share calories with patient or family

IV Fluids:
- Isotonic bolus reserved for severe dehydration (Dextrose fluids may cause refeeding syndrome)
- Use smaller bolus if signs of heart failure)

ARFID:
- Complete multivitamin 1 tablet daily
- Thiamine 100 mg/day x7 days total
- Calcium carbonate for low calcium levels
- Replete phosphorus if low for age [Consider IV phos if severe]
- Replete potassium if low for age [Consider IV KCl if severe]
- If constipated, consider Polyethylene Glycol 17g 1-2x/day

Severe Vomiting:
- Consider sodium bicarbonate or oral Bicitra if bicarbonate levels are low
- Consider potassium supplement if normal serum K and signs of metabolic acidosis (may indicate dangerous reduction of total body potassium)

y
f meeting medical
r each level
s with SBP < 80 or
ogic instability
se only
n admission
als
or scheduled child
eelchair rides as
tient team
edical & psych
eight
room
it weight and
eight defined as
on pathway
equire 1 five-
t gain
equire 2 five-
y
t gain
equire 3 five-
y (= home ADLs)
ion:
progress, or at any
e identified, care
gher observation
patient is not
dequate nutrition

Consult:
- Consult OT and SLP (feeding team)

Reinforcement:
See Appendix H ARFID Behavioral Plan

- Behavioral plan will be created with multidisciplinary input, identifying:
  - Patient motivators
  - Reinforcers for small goals
  - Reinforcers for large goals
  - Less desirable activities when goals are not met

Meal Support
- See Appendix B: Nursing/PCA Job Aid and Appendix G: Meal Support Strategies
- See Appendix I for nursing/PCA protocol worksheet

Discharge
- Continued weight gain with maximum activity level and
- Adherent to prescribed nutrition plan, received relevan
- Scheduled appointments made with outpatient multid
- If being discharged to higher level of care, meets progr
- Medications at discharge: complete multivitamin; thia

d SBP > 80
, and therapy
rmed

RE
THE

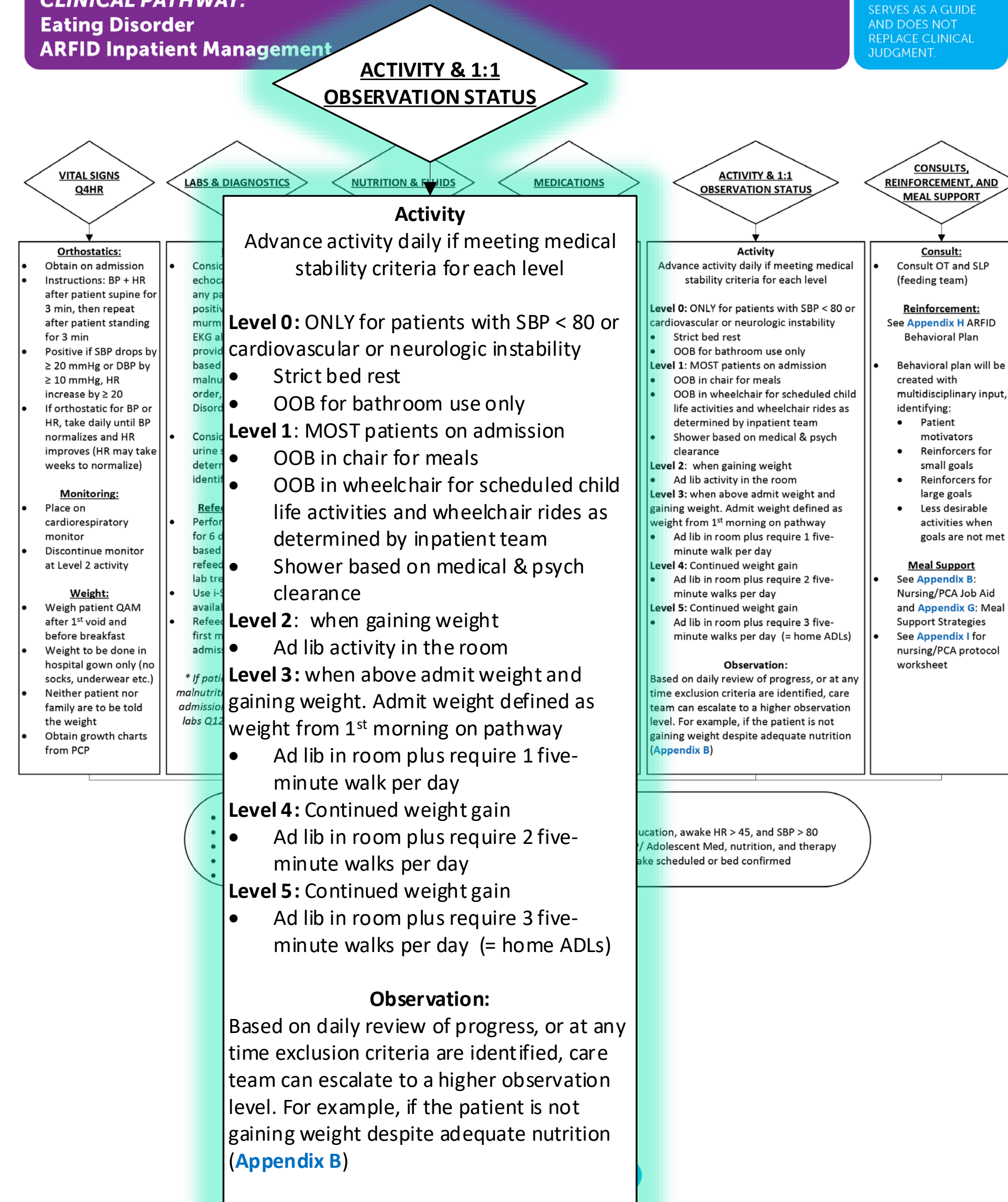
CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROV

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Activity Status:

- Activity advancement is the same for ARFID and anorexia/bulimia



CLINICAL PATHWAY:
Eating Disorder
Appendix H: ARFID Behavior Plan Template

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Patient Name: ______________________________ Date: ____________________

Reinforcers:

Tablet Coloring pages Arts/Crafts Games

TV/Movies Wheelchair rides Visits with friends Visits with family

Other:

Small Goals:

Touch a new food Take ____ bite(s) of a new food Eat ____% of a new food

Taste a new food Eat _____% of a familiar food Drink _____ medicine cups of a drink

Other:

Reinforcer for small goal (ex. 15 minutes of tablet)

____

Large Goals:

Eat _____% of the meal Eat 100% of a familiar food Drink a cup of a drink

Other:

Reinforcer for Large Goal (ex. 2 hours arts/crafts with sister)

____

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved

Behavior Plan

- Occupational therapy and Speech Language Pathology (feeding team) are consulted for all patients with ARFID
- An individualized behavioral plan will be created to enhance nutritional compliance for children with ARFID

CLINICAL PATHWAY:
Eating Disorder
ARFID Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

CONSULTS, REINFORCEMENT, AND MEAL SUPPORT

VITAL SIGNS Q4HR | LABS & DIAGNOSTICS | NUTRITION & FLUIDS | MEDICATIONS | ACTIVITY & 1:1 OBSERVATION STATUS | CONSULTS, REINFORCEMENT, AND MEAL SUPPORT

Orthostatics:
- Obtain on admission
- Instructions: BP + HR after patient supine for 3 min, then repeat

Day 1:
- Consider echocardiogram for any patient with a positive cardiac ROS,

Nutrition:
[See Appendix E for ARFID plans]
- Initiate meal plan immediately after admission lab results

ARFID:
- Complete multivitamin 1 tablet daily
- Thiamine 100 mg/day x7 days total
- Calcium carbonate for low calcium levels

Consult:
- Consult OT and SLP (feeding team)

Reinforcement:
See Appendix H ARFID Behavioral Plan

- Behavioral plan will be created with multidisciplinary input, identifying:
  - Patient motivators
  - Reinforcers for small goals
  - Reinforcers for large goals
  - Less desirable activities when goals are not met

Meal Support
- See Appendix B: Nursing/PCA Job Aid and Appendix G: Meal Support Strategies
- See Appendix I for nursing/PCA protocol worksheet

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

CLINICAL PATHWAY:
Eating Disorder
Appendix G: Meal Support Strategies

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Get the patient's and family's input
- What strategies have worked in the past?
- Would you like to talk about something while you're eating?
- Would you like to listen to me while eating?
- Get to know the patient's interests

Distraction – Engage in conversation about topics unrelated to food
- Categories – pick a topic (animals, items found at the mall, places…) take turns coming up with items in chosen category beginning with the letters of the alphabet in order.
- Going to the beach, on a hike, or going shopping – Starting in alphabetical order take turns saying something that you would find or take with you. (A- ant, B-ball…).
- 20 questions – one person thinks of something (person, place, or object) the other person has to correctly identify and name it by asking "yes" or "no" questions. Then switch rolls (thinker becomes the question asker).
- Mad libs

For Young Children with ARFID

Be a food scientist
- What do you see? (shape, color, size)
- What does it feel like? (hard, soft, bumpy, smooth, fuzzy, wet, slippery, dry)
- What does it smell like? (sweet, sour, spicy, mild, strong)
- What does it taste like? (sweet, salty, tart, fruity, spicy)
- What does it sound like? (loud, quiet, crunchy, no sound)

Hokey Pokey: (you put the broccoli in, you take the broccoli out, you put the broccoli in and you move it all around)

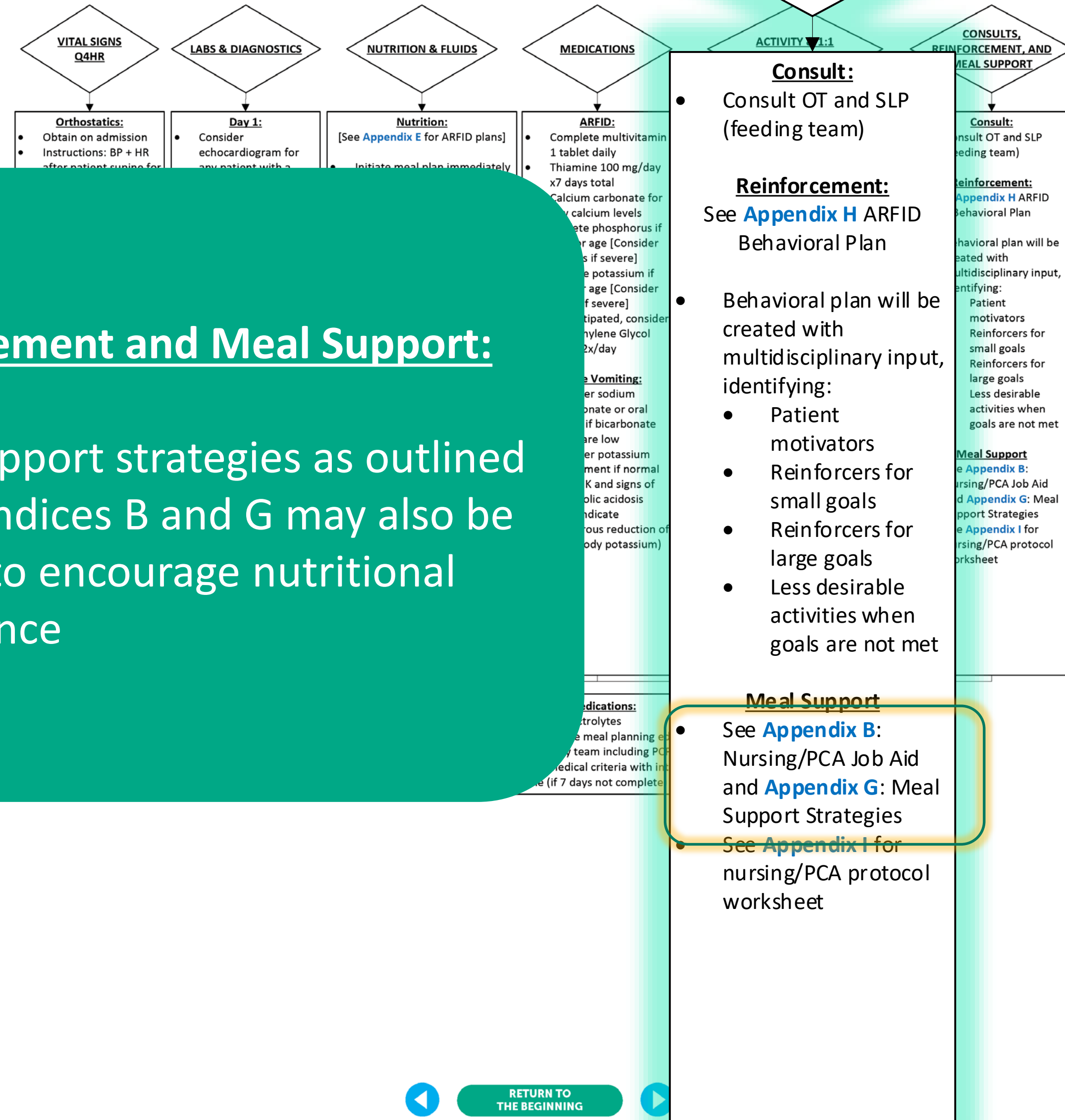
Eat around the plate – use at least **3** foods (1. something always eaten, 2. something occasional eaten 3. something USED TO eat or something never eaten)
- First, use all preferred foods to teach protocol and reduce anxiety
- Use a divided plate or small bowls - have child place 2-3 preferred foods into each section
- Teach rules of even rotation (1 bite from each section of plate/bowl)
  Alternate difficult foods and easy foods - begin with reinforcing each bite of new food, progress to reinforcing following full sequence completion
  - Difficult food may first be an occasionally eaten food or a food with a slight change to taste, texture or brand
  - Gradually progress to a never eaten food
  - If unable to actually eat food, reward any attempts to move up food hierarchy (touch, kiss, lick bite)

***** You can play a game while following the above "eat around the plate" progression – such as candy land, chutes and ladders, trouble, UNO *****
- Assign a food to each color OR assign a food to each number
- Take turns playing the game, taking bites of the assigned food

©2019 Connecticut Children's Medical Center. All rights reserved.

Reinforcement and Meal Support:

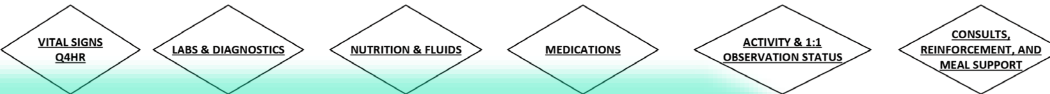
- Meal Support strategies as outlined in Appendices B and G may also be helpful to encourage nutritional compliance



©2019 Connecticut Children's Medical Center. All rights reserved.

CLINICAL PATHWAY:
Eating Disorder
ARFID Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.



Discharge Criteria/Medications:

- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

Discharge Criteria/Medications

- Discharge criteria and medications for ARFID are the same as Anorexia/Bulimia

Refeeding Labs:
- Perform Chem 10 daily for 6 days, then PRN based on risk of refeeding syndrome & lab trends
- Use i-STAT when available
- Refeeding lab Day 1 = first morning of admission

** If patient has severe malnutrition or abnormal admission labs, consider labs Q12 hours initially*

- nutrition supplement replacement guideline
- The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team (See Appendix E regarding NGT feedings)
- Do not share calories with patient or family

IV Fluids:
- Isotonic bolus reserved for severe dehydration (Dextrose fluids may cause refeeding syndrome)
- Use smaller bolus if signs of heart failure)

- Consider sodium bicarbonate or oral Bicitra if bicarbonate levels are low
- Consider potassium supplement if normal serum K and signs of metabolic acidosis (may indicate dangerous reduction of total body potassium)

Activity

gaining weight. Admit weight defined as weight from 1st morning on pathway
- Ad lib in room plus require 1 five-minute walk per day

Level 4: Continued weight gain
- Ad lib in room plus require 2 five-minute walks per day

Level 5: Continued weight gain
- Ad lib in room plus require 3 five-minute walks per day (= home ADLs)

Observation:
Based on daily review of progress, or at any time exclusion criteria are identified, care team can escalate to a higher observation level. For example, if the patient is not gaining weight despite adequate nutrition (Appendix B)

Consult:
- Consult OT and SLP (feeding team)

Reinforcement:
See Appendix H ARFID Behavioral Plan

- Behavioral plan will be created with multidisciplinary input, identifying:
  - Patient motivators
  - Reinforcers for small goals
  - Reinforcers for large goals
  - Less desirable activities when goals are not met

Meal Support
- See Appendix B: Nursing/PCA Job Aid and Appendix G: Meal Support Strategies
- See Appendix I for nursing/PCA protocol worksheet

Discharge Criteria/Medications:
- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

CONTACTS: CHRISTINE SKURKIS, MD | ALYSSA BENNETT, MD | LISA NAMEROW, MD | DAKOTA MICHAUD, RD

LAST UPDATED: 04.16.26

©2019 Connecticut Children's Medical Center. All rights reserved.

Review of Key Points

Connecticut Children's

- Restarting nutrition safely can prevent refeeding syndrome
- Weight gain and gradual medical stability should occur in a structured manner
- Encourage the patient to take nutrition by mouth with simultaneous medical and psychological care
- Develop a discharge plan with appropriate referrals

Quality Metrics

Connecticut Children's

- % Patients with pathway order set (ARFID/NON-ARFID)
- AVG time (minutes) from hospital admission to pathway order set (ARFID/NON-ARFID)
- % Patients who require NG placement (ARFID/NON-ARFID)
- % Patients with 1 NG tube placement (ARFID/NON-ARFID)
- % Patients with 2 NG tube placements (ARFID/NON-ARFID)
- % Patients with > 2 NG tube placements (ARFID/NON-ARFID)
- % Patients with Hypophosphatemia who receive phosphorus supplement (ARFID/NON-ARFID)
- AVG time (days) from hospital admission to Order Activity 5 (ARFID/NON-ARFID)
- # Patients readmitted (ARFID/NON-ARFID)
- ALOS (Days) (ARFID/NON-ARFID)

Pathway Contacts

Connecticut Children's

- Christine Skurkis, MD
  - Pediatric Hospital Medicine
- Lisa Namerow, MD
  - Child and Adolescent Psychiatry
- Alyssa Bennett, MD
  - Adolescent Medicine
- Dakota Michaud, RD
  - Clinical Nutrition

References

- Amianto, Federico et al. Psychological Effects of Nasogastric Tube (NGT) in Patients with Anorexia Nervosa: A Systematic Review. Nutrients 2024, 16, 2316. https://doi.org/10.3390/nu16142316
- The American Psychiatric Association Practice Guideline for the Treatment of Patients with Eating Disorders. Fourth Edition. Feb 2023. https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890424865
- Bern EM, et al. Variation in care for inpatients with avoidant restrictive food intake disorder leads to development of a novel inpatient clinical pathway to standardize care. J Eat Disord. 2024 May 23;12(1):66. PMID: 38783304; PMCID: PMC11112782. https://doi.org/10.1186/s40337-024-01018-8
- Horovitz. Advancements in the Diagnosis and Treatment of Eating Disorders in Children and Adolescents: Challenges, Progress, and Future Directions. Review. Nutrients 2025, 17, 1744 https://doi.org/10.3390/nu17101744
- Kaplan et al. Evaluation of an eating disorder screening and care pathway implementation in a general mental health private inpatient setting. Journal of Eating Disorders (2024) 12:119. https://doi.org/10.1186/s40337-024-01077-x
- Krug et al. A meta-analysis of mortality rates in eating disorders: An update of the literature from 2010 to 2024. Clinical Psychology Review. 116 (2025) 102547. https://doi.org/10.1016/j.cpr.2025.102547
- Rajagopalan, Aishwarya et al. Protocol-based Interventions for Inpatient Medical Stabilization of Anorexia Nervosa in Children and Adolescents. Psychiatric annals, 2025-11, Vol.55 (11), p.e262-e266
- Riss et al. A Bitter Pill: The Ethics of Involuntary Treatment of Adolescents With Severe Eating Disorders. Hospital Pediatrics. Volume 15, Issue 2, February 2025. https://doi.org/10.1542/hpeds.2024-007921
- Rosen, E. et al. (2023). Renal fluid and acid/base balance during refeeding in restrictive eating disorders. *International Journal of Eating Disorders*, 56(3), 574–581. https://doi-org.online.uchc.edu/10.1002/eat.23873
- Shook, Jennifer; Brady-Olympia, Jodi. The Inpatient Management of Adolescents with Eating Disorders. Pediatric annals, 2024-08, Vol.53 (8), p.e283-e287

Thank You!

About Connecticut Children's Pathways Program

Clinical pathways guide the management of patients to optimize consistent use of evidence-based practice. Clinical pathways have been shown to improve guideline adherence and quality outcomes, while decreasing length of stay and cost. Here at Connecticut Children's, our Clinical Pathways Program aims to deliver evidence-based, high value care to the greatest number of children in a diversity of patient settings. These pathways serve as a guide for providers and do not replace clinical judgment.