Do This, Don't Do That:

An Evidence-based Approach to Patients Who Choose to Discharge Prematurely

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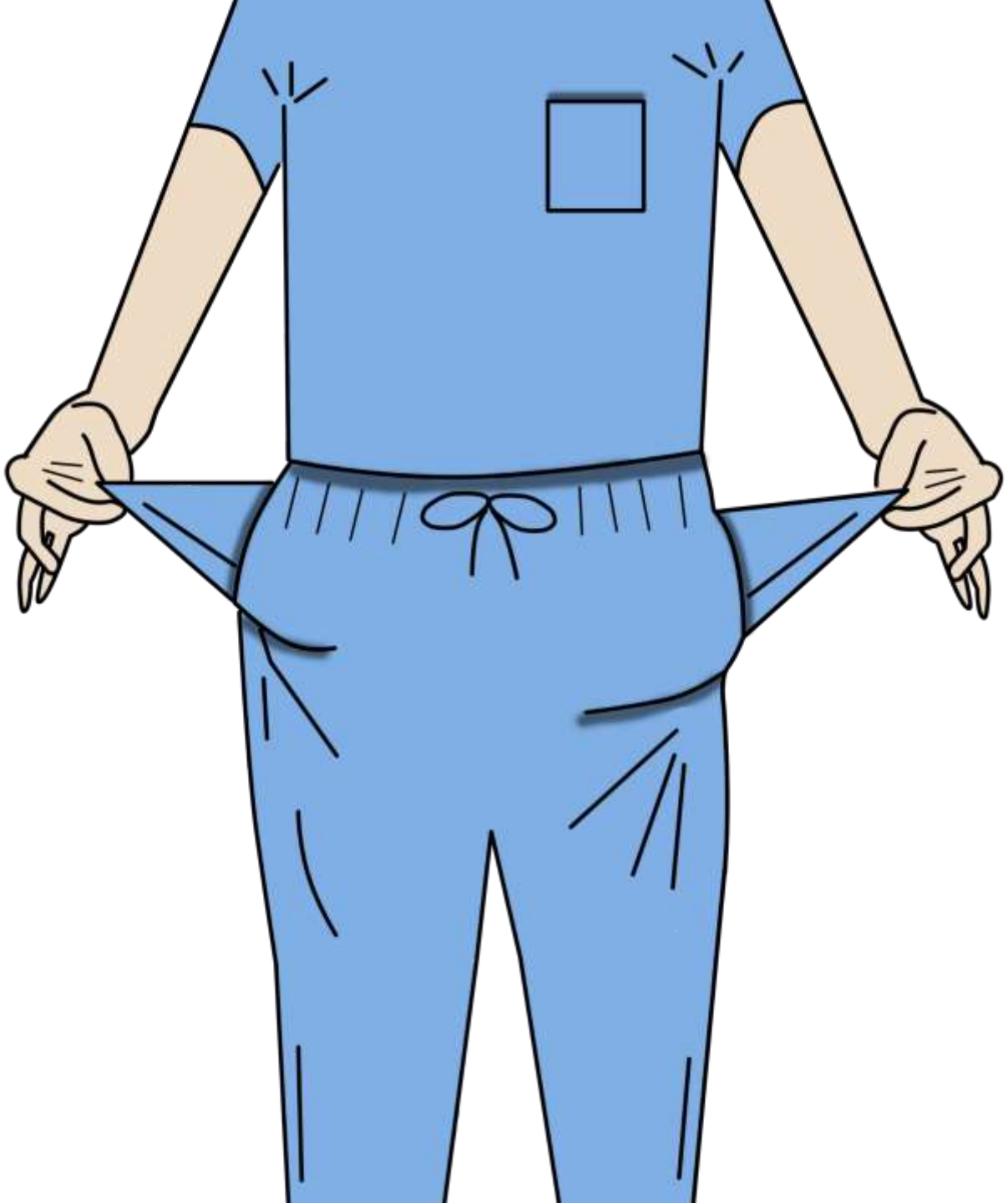
Disclosure

I have no conflicts of interest, financial or otherwise.

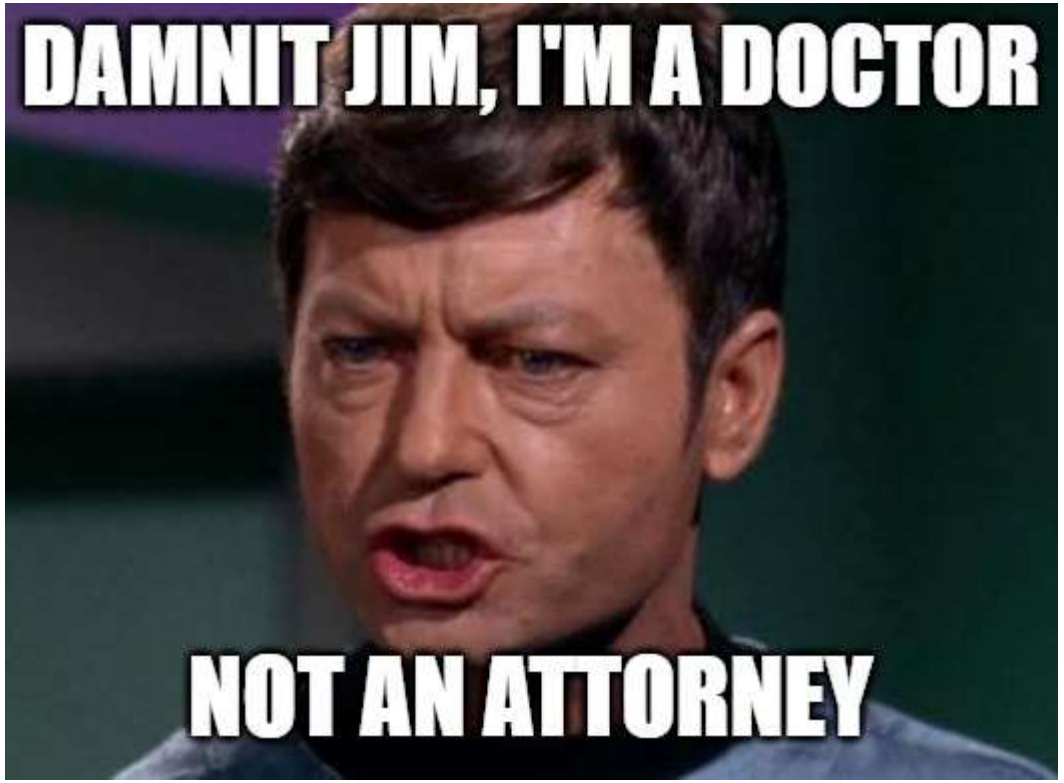


Disclaimer

While this content is heavily researched and evidence-based, I am **not** an attorney or risk management specialist.

This presentation is for your general information only and should not be considered personalized legal advice.

Please consult your hospital policies and department of risk management for details relating to your own situation.



Learning Objectives

1. Describe who leaves AMA and why they do so
2. Utilize patient-centered, non-stigmatizing language
3. List the four elements of decision-making capacity
4. Apply a patient-centered approach to AMA discharges
5. Discuss risk mitigation strategies for avoiding malpractice litigation

Roadmap

1. Background
2. Best practices
   - Capacity
   - Risk mitigation
   - Documentation
3. Conclusion

Do This

Don't
Do That

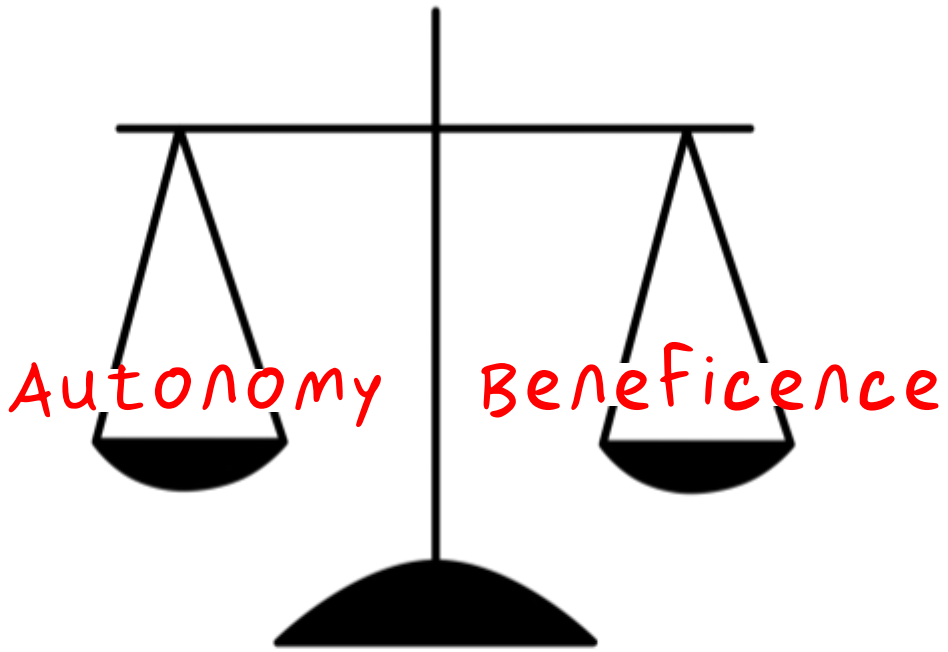
Case

Ms. Jones is a 40-year-old woman with a history of houselessness and opioid use disorder who is hospitalized with MRSA bacteremia and endocarditis.

During her admission, she reports increasing symptoms of uncontrolled opioid withdrawal and makes several comments about leaving the hospital “AMA”.

Why this topic matters

Patient-centered & ethical care



Avoiding malpractice litigation

August 6, 2018

Physician Sued After Letting Patient Leave Against Medical Advice

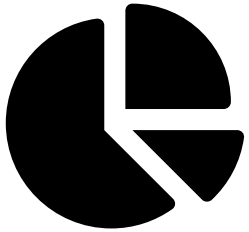
Ann W. Latner, JD

This month we look at a case involving leaving the hospital against medical advice (often referred to as leaving 'AMA'). Generally, if a patient leaves the health-system AMA, and it was thoroughly documented by the physician, then the physician is protected if the patient suffers consequences from his own actions. However, there are some instances where AMA is far less likely to work as a defense. This case is a good example of one of these instances.

Mr G was adamant that he did not want to remain in the hospital

https://www.empr.com/home/features/physician-sued-after-letting-patient-leave-against-medical-advice/

Background: AMA Discharges

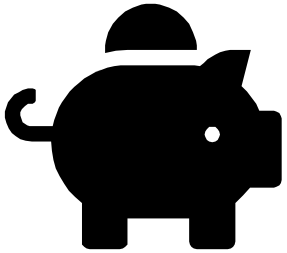


1-2%

Of all hospital discharges

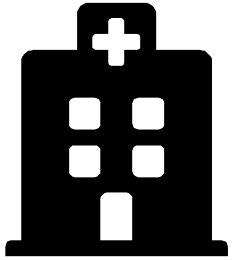
2-4x

Odds of 30-day readmission



$822 million

Cost nationwide (2014)

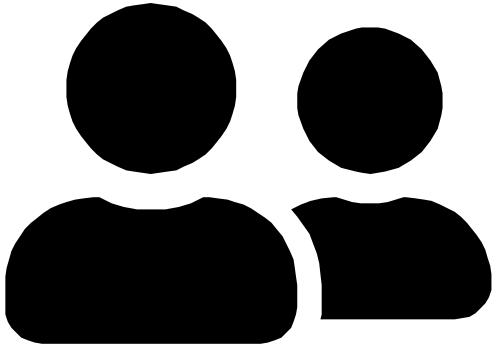


>400,000

Hospitalization days (2014)

Tan et al. JAMA Netw Open. 2020;3(6):e206009.
Spooner et al. Annals of Epidemiology. 2020;52:77-85.e2.

Background: AMA Discharges

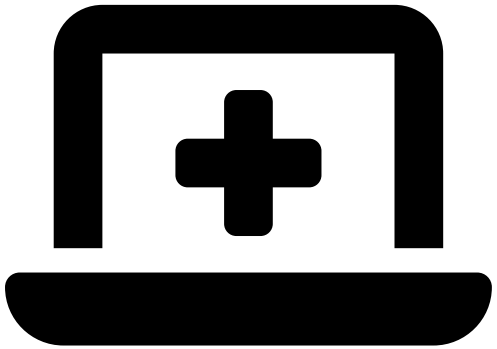


Disproportionately affect those with low income, houselessness, mental illness, and addiction.

Tan et al. JAMA Netw Open. 2020;3(6):e206009.
Spooner et al. Annals of Epidemiology. 2020;52:77-85.e2.

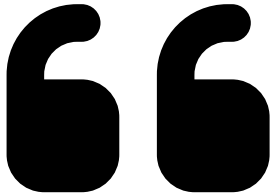
Background: AMA Discharges

Less likely to return for follow up care



Can perpetuate long-lasting stigma

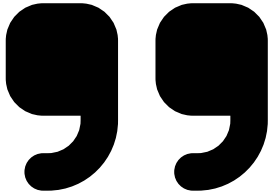
Alfandre et al. Journal of Hospital Medicine. 2017;12(10):843-845.



…50 year old man with a history of drug abuse and frequent AMAs…

…49 year old non-compliant woman who…

…patient is threatening or demanding to leave AMA…



Mr. Davis is a 50 year old man hospitalized with pneumonia. On HD#2 he decided to discharge prior to completion of the recommended treatment course due to lack of childcare at home.

Why do patients leave AMA?

1. Stigmatization and discrimination by staff
2. Inadequate management of withdrawal
3. Uncontrolled acute or chronic pain
4. Hospital rules and restrictions
5. Feelings of boredom and confinement
6. Isolation from family/social support

Heralds of ‘impending AMA’ present in 75% of charts

Edwards et al. J. Hosp. Med. 2013;8:574-577.
Pollini et al. Int J Drug Policy. 2021;94:103206.
Simon et al. Subst Abus. 2020;41(4):519-525.

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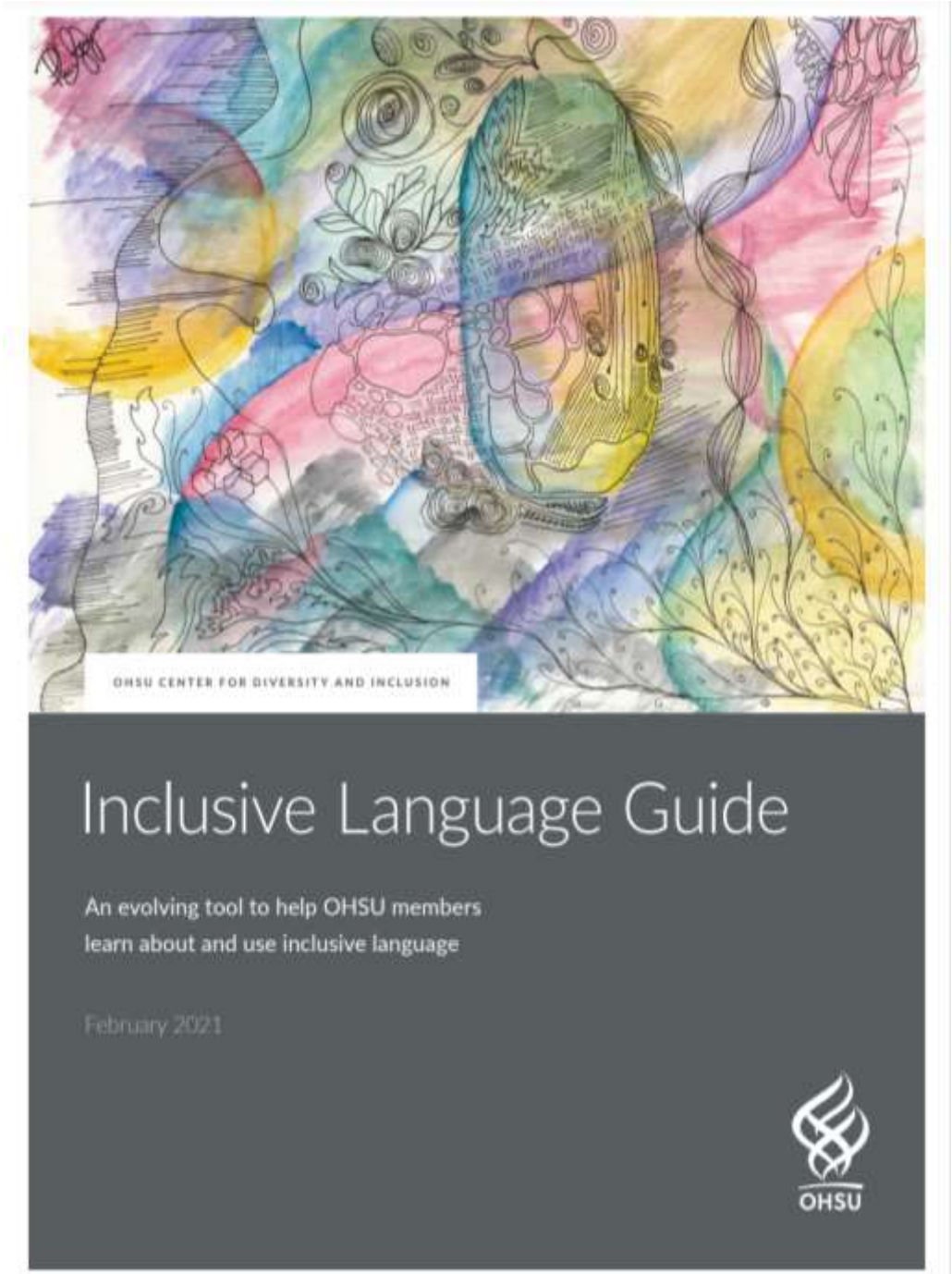


Avoid Labels

"When we label people, it is as if that word wholly and forever defines them; it can also trigger biases."

Substance use disorder

"A disease that affects a person's brain and behavior and leads to an inability to control use of a legal or illegal medication or drug."

Use non-stigmatizing, patient-first language

https://www.ohsu.edu/center-for-diversity-inclusion.

Preempting AMA discharges

1. AMA discharges have been shown to be associated with receiving fewer opioid agonist administrations and lower methadone dosing.

2. Medications for opioid use disorder (bup/nal, methadone) are strongly associated with reduced rates of AMA discharge.

3. Addiction medicine consult services reduce 90d readmissions among PWID leaving AMA (aHR 0.57, 95% CI 0.38–0.86).

Provide evidence-based care for patients with opioid use disorder.

Santos et al. Journal of Addiction Medicine. 2021; 15(1):49-54.
Kays LB et al. Hosp Pharm. 2022 Feb;57(1):88-92.
Wang SJ et al. Am J Med. 2020 Nov;133(11):1343-1349.
Chan et al. J Acquir Immune Defic Syndr. 2004;35(1):56-9.
Marks et al. Clinical Infectious Diseases. 2020;71(10):e650-656.

Case

Ms. Jones continues to report inadequate symptom control and becomes increasingly agitated.

On hospital day 4, you receive the following page from the nurse while sitting in the workroom:

Case (continued)

Your colleague happens to see the page.

“Be sure to tell your patient that insurance won’t pay if he leaves AMA,” he says. “He’ll be stuck with the bill. That might convince him to stay.”

True or False?

Insurance providers will not (or may not) pay for hospitalizations in which the patient leaves against medical advice.

A. True

B. False

Urban legend!

- Retrospective review (2001 – 2010)
- N=46k patients, 526 left AMA (1.1%)
- **<u>0 cases</u>** of payment refusal because pt. left AMA

Common misconception:

69% of residents

44% of attendings

Don’t misinform patients about financial consequences of leaving AMA.

Schaefer et al. J Gen Intern Med. 2012 Jul;27(7):825-30.

Case (continued)

You arrive at Ms. Jones' bedside. You tell her your concerns, but she is intent on leaving the hospital, stating her symptom control has been inadequate.

You proceed to assess whether she has decision-making capacity.

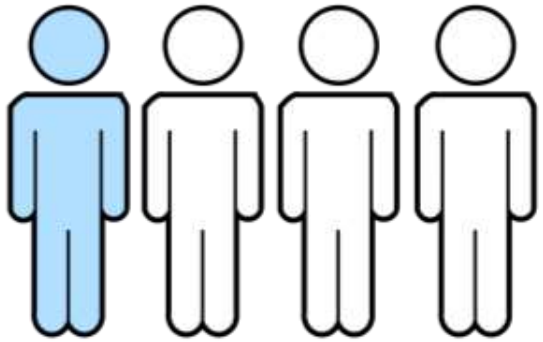
Which of the following are the required elements of capacity?

A. Choice, risks, benefits, alternatives
B. Situation, risks, choice, consequences
C. Choice, logic, memory, insight
D. Understanding, appreciation, reasoning, choice

Decision-making capacity

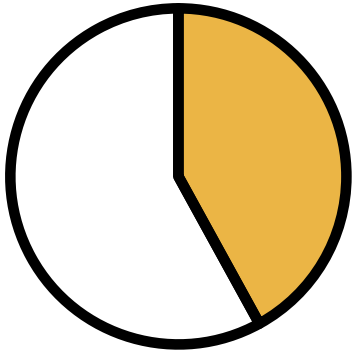
The ability to utilize available information to make informed decisions about one's health in line with personal values.

- Situational: decision and risk specific
- Temporal: can change over time



1 in 4 acutely ill medical inpatients lacked decision-making capacity

COMMON



Physicians recognized incapacity in only **42%** of affected patients

UNDER-RECOGNIZED

Sessums et al. JAMA. 2011; 306(4):420-427.

Four elements of capacity

Understanding

Know meaning of key info

Intelligence/Memory

Appreciation

Apply key info to self

Insight/Denial/Delusions

Reasoning

Compare and infer

Logic/Values

Choice

State a decision

Ambivalence/Consistency

Can you tell me why you’re in the hospital?
What is your most serious health problem right now?
What you have been told about your condition?
What is the recommended treatment?
Are there any other options?

Do you think this treatment could help you get better?
What could happen if you don’t have the treatment?
What are the risks of leaving the hospital now?
Can you tell me why I’m worried about you leaving?

“What is your reason for making this decision?
Help me understand why you’re foregoing treatment?
Why is it more important to leave than be treated?”

Case (continued)

You determine Ms. Jones has capacity to choose to discharge prematurely.

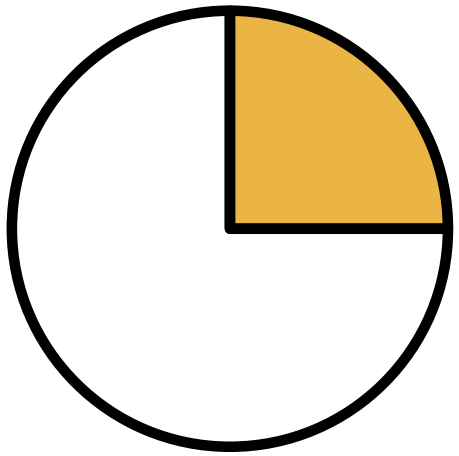
Which of the following is your next step in your discharge process?

A. Prescribe a oral antibiotic (suboptimal therapy)
B. Counsel on return precautions
C. Schedule outpatient follow up
D. All of the above; reasonable efforts should be made to coordinate outpatient care
E. None of the above; these may put the discharging physician at risk of litigation

Discharge process: best practices

Misconceptions are <u>common</u>

- Survey of 389 physicians at 9 academic hospitals:



<u>25% of interns</u> thought policies limited the care they could provide to patients discharging AMA.

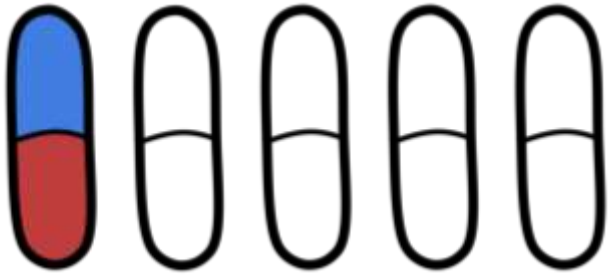
Plasencia A et al. Abstract published at HM16. Abstract 141. JHM. 2016; Volume 11, Suppl 1.

Discharge process: best practices

Best practices are <u>often not followed</u>

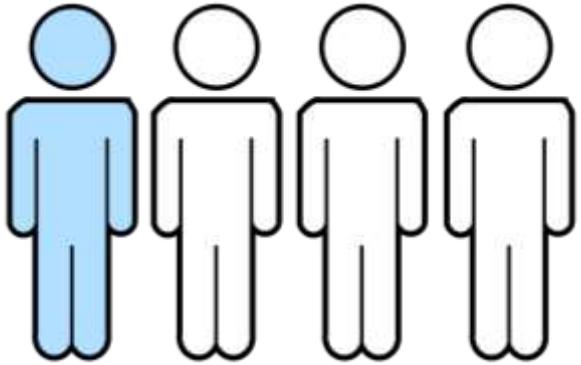
- Retrospective review of 319 AMA discharges:

~1 in 5 patients



had medications prescribed

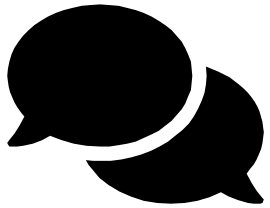
~1 in 4 patients



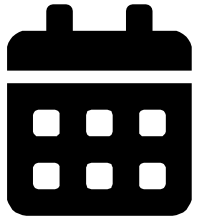
had follow up arranged

Cordelia et al. Journal of Hospital Medicine. 2017;12:11-17.

Patient-centered stepwise approach



Ask why

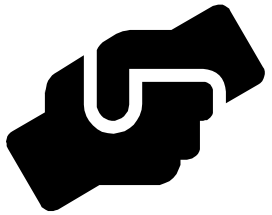


Schedule follow up

Discuss risks

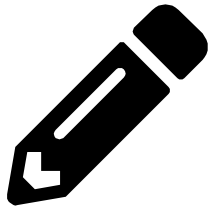
Answer questions

Assess capacity



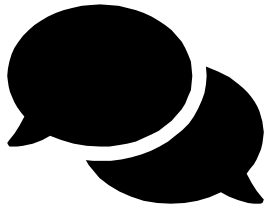
Encourage return

Provide meds



Document thoroughly

Patient-centered stepwise approach



Ask why

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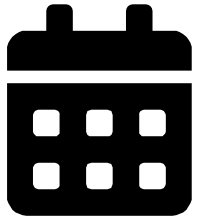
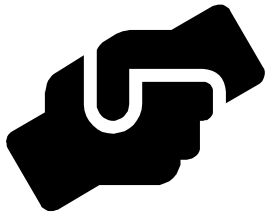


Schedule follow up

Answer questions



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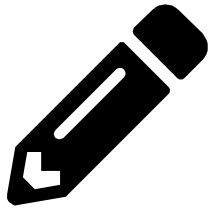


Document thoroughly

Patient-centered stepwise approach

Ask concerns

Schedule follow up

An AMA discharge should be approached just like a regular one, but with the addition of a thoroughly documented capacity assessment.

Provide meds

Document thoroughly

Case (continued)

As you are working on the discharge paperwork, the nurse hands you a form.

“Don’t forget to have her sign this,” he says. “That way she can’t sue.”

Risk mitigation strategies

Which of the following is the single best strategy for mitigating risk of future malpractice litigation?

A. An AMA form signed by the patient
B. Thorough documentation of the discussion in the EHR
C. Plugging your ears and yelling “LA-LA-LA, I CAN’T HEAR YOU!”

Risk mitigation strategies

- No medico-legal requirement to designate as “AMA”
- Boilerplate AMA forms alone offer little defense
  - ➢ Have been ruled as a “nullity” (aka legally void)
- Proper counseling/documentation does offer legal protection

Alfandre et al. Journal of Hospital Medicine. 2017;12(10):843-845.
Devitt et al. Psychiatric Services. 2000;51(7):899-902.
Battenfeld v. Gregory, Lyons v. Walker, Griffith v. University Hospital of Cleveland
Levy et al. The Journal of Emergency Medicine. 2012; 43(3):516-520.

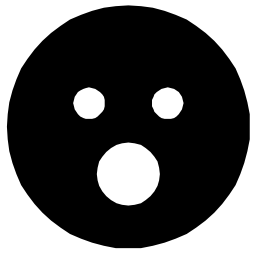
Risk mitigation strategies

Documentation is often suboptimal:

2/3
Risk-benefit discussion

2/3
Informed consent

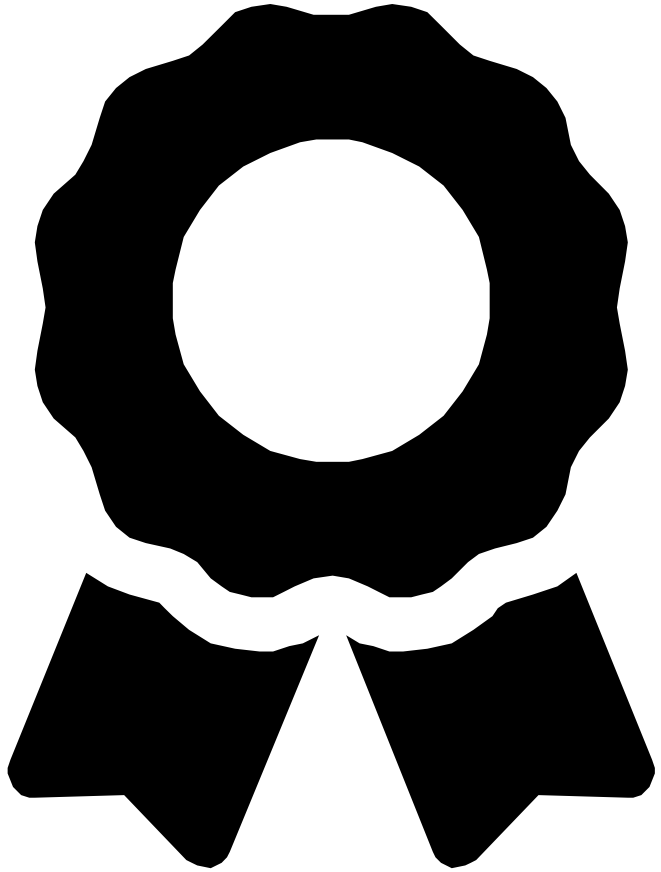
1/3
Capacity assessment

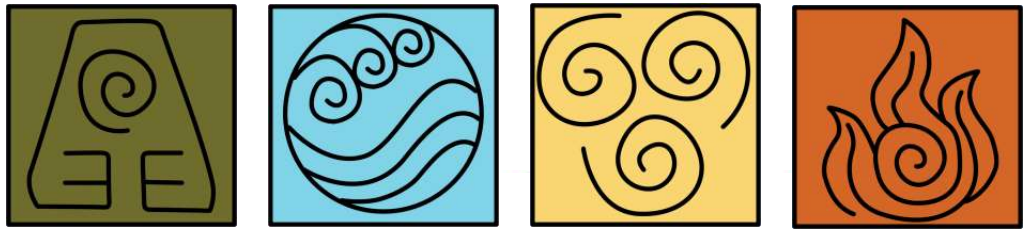


Tummalapalli SL et al. J Healthc Qual. 2020 Sep/Oct;42(5):269-277.
Cordelia et al. Journal of Hospital Medicine. 2017;12:11-17.

Documentation: best practices

- Reason they are choosing to leave
- Efforts taken to get them to stay
- Specific risks/benefits discussed
- All 4 elements of capacity
- Return precautions
- Encouraged to come back if worse
- Steps to coordinate ongoing care
- Questions were answered





Don't Do That

How was this assessed?

she did not want to remain hospitalized and wanted to leave the hospital. She demonstrated decisional capacity to the overnight cross cover resident and was allowed to leave against medical advice.

Which ones?

Multiple providers, including myself, reviewed the risks of discharging without complete treatment and workup for his MSSA bacteremia, presumed endocarditis and he demonstrated understanding by repeating back. No capacity concerns. He was willing to accept Rx for oral bactrim to continue. He was not willing to wait for IV dalbavancin dose.

Do This

@NAME@ requested to leave the hospital prior to completing the recommended treatment course for the following reason: ***. I personally discussed the risks (and potential benefits) of leaving today vs. staying for additional treatment, including but not limited to the following: ***. They demonstrated capacity to make this decision by expressing understanding of the relevant information ("*direct quotation*"), appreciation of the consequences ("*direct quotation*"), logical reasoning ("*direct quotation*"), and a consistent choice. Questions were answered. Prescriptions were sent to their pharmacy and I recommended they follow up ***. I counseled them return precautions (***) and encouraged them to return if they were to get worse.

Case (conclusion)

You prescribe Ms. Jones antibiotics, schedule PCP follow up, discuss return precautions, and answer her questions. You give her resources on local addiction treatment services. Afterward, you thoroughly document your conversation and capacity assessment in the EHR.

Take home points: “AMA” discharges …

- Are very common (1-2%)
- Frequently result in re-admission (2-4x)
- Disproportionately impact our most vulnerable patients
- Can be highly stigmatizing
- May decrease the likelihood patients will return for care
- Are, strictly speaking, unnecessary

Use patient-first, non-stigmatizing language	Use terms like “addict” or “drug abuse”
Provide evidence-based care for opioid use disorder	Under-treat pain and withdrawal
Contextualize reasons for AMA decisions whenever possible	Contribute to stigma propagation in the EHR
Use shared decision-making rather than coercion	Tell patients insurance won’t pay for AMA

Assess and document all 4 elements of capacity	Rely on AMA forms for risk mitigation

UNDERSTANDING

APPRECIATION

REASONING

CHOICE

Assess and document all <u>4 elements</u> of capacity	Rely on AMA forms for risk mitigation
Document completely and thoroughly	Write: “Risks discussed. Patient has capacity.”
Approach D-AMA like routine ones: meds, f/u, return precautions, Qs	Believe that “AMA" designation serves any medico-legal purpose

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Thank You!

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