Discharge against medical advice

Leading practices for preventing and managing discharges against medical advice

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Significance of the problem

About 2% of all hospital discharges are against medical advice (AMA).[1-3] AMA discharges are associated with increased morbidity, mortality, and readmissions.[1-5] Clinical, professional, or regulatory standards do not exist for AMA discharge;[6,7] therefore, provider practices are subjective, variable, and lack an individualized patient approach.[6,8,9,10] AMA discharges may be stigmatizing for the patient, reduce the patient's likelihood of accessing follow-up care, and impede the quality of informed consent discussions and discharge planning.[7]

20-30%

Patients who are discharged against medical advice are more likely to be readmitted.[1,2,4,5]

At-risk patients

Risk factors commonly associated with patients who are discharged AMA include male gender,[1-3,11] younger age,[1-3] alcohol and substance use, mental illness, HIV/AIDS,[2-4,6,12,13] lack of a primary physician or health insurance,[2,3] patients who are on Medicaid,[1-3,14,15] a history of a previous AMA discharge,[13,15] a lower household income,[1,3,7,11,13] and homelessness.[4] Patients with substance use issues are up to 3 times more likely to be discharged AMA, and physicians often feel ill-equipped to diagnose or treat substance use disorder (SUD).[4,6] SUD patients often leave due to inadequate treatment of their withdrawal, cravings or pain, stigmatization, or hospital restrictions;[6] however, they may not be upfront about their true reason for leaving.[16] Conversely, in-hospital methadone and social support have been shown to reduce the likelihood of an AMA discharge.[12]

Leading practices

Intervene proactively to prevent AMA discharge

- Create a culture of empathy and compassion for patients regardless of their differences and intervene to address stigmatizing behaviors among staff and providers.[6,7,17]
- Prioritize and support patient engagement and preferences.[7,18]
- Engage patients in shared decision making about their treatment plan. Take an individualized approach to discharge based on patient's clinical and psychosocial risks.[7,18]
- Develop a protocol to identify patients at-risk of leaving AMA and strategies aimed at early intervention.[11]

- Implement a process for timely consultation, evaluation and interventions for substance use disorder, mental illness and pain management and engagement in addiction treatment.[6,17]
  - Addiction consult teams have been effective in initiating pharmacotherapy (e.g., buprenorphine or methadone for opioid use disorder), engaging the patient through motivational interviewing, and facilitating aftercare to community-based treatment programs.[6,7] Early consultations by psychiatric clinical liaisons have reduced the likelihood of medical patients signing out AMA.[17]
    - Listen to the Vizient PSO webinar on *Treating substance use disorder in hospitals: engaging people and changing systems* to learn about Oregon Health & Science University's (OHSU) approaches to hospital addictions care including addiction consult services, workforce development, and hospital-community partnerships. Access this webinar at Vizient PSO webinars in the Safety Topical section.
  - Peer recovery coaches with lived experience and recovery have been integrated into healthcare settings to engage and support individuals with substance use disorder and provide them with resources to help them toward recovery. The use of peer recovery coaches has demonstrated decreased hospitalizations, ED visits, and substance use.[6,19]
    - Learn more about how Indiana University Health connects ED patients with a substance use disorder to peer recovery coaches virtually.
- Utilize a collaborator—a social worker, case manager or nurse skilled in dealing with patients at risk for AMA discharge—that assists the patient in addressing barriers to optimal care such as family, work, or other social obligations.[16,17] The use of nurse patient advocates that explored the patient's preconceptions about hospitalization and addressed their fears and complaints resulted in a 30% reduction in AMA discharge.[17]
- Include patients and family advisors and care partners in leadership, governance, and safety and improvement efforts.

Appropriately manage requests for premature discharge

- Develop a standardized protocol for clinicians to address the patient's decision-making capacity, follow-up plan, discharge arrangements, and communication with the primary care provider.[16]
- Contact the attending physician to discuss the severity of illness, rationale for treatment, and reasons hospitalization is recommended with the patient. Discuss and document the patient's symptoms and the providers concerns, the extent and limitation of the exam, recommended treatment plan, risks of foregoing treatment including complications, disability, and death, and review alternative diagnostics and treatments to obtain informed consent. Inform the patient about reasons to return to the ED.[1,16,18,20]
- Utilize a shared decision-making model to determine the best course for the patient.[7,18]
- Assess and document decision making capacity (validate with primary MD regardless of time of day).[14,17,18,20] If necessary, obtain a psychiatric or neuropsychological evaluation to determine the extent to which mental illness impairs capacity and whether it can be ameliorated.[17] When a patient lacks decision-making capacity, ensure compliance with accrediting body, state, local and/or federal requirements/regulations, advanced directives, and organizational policy. Collaborate with the patient and authorized representative to develop a plan that is in the best interests of the patient and respects their wishes.[21]

- When many conflicts of interest arise or when a surrogate is not available or disagreement persists about who is the appropriate surrogate in cases of limited decision-making capacity, obtain an ethics consultation to help with decision-making.[17,21]
- Develop and discuss an optimal discharge plan with outpatient therapies that may be helpful, even if suboptimal, and complete the discharge summary including post discharge care plan.[7] Ensure the discharge discussion is communicated in a manner that is understood by the patient.[17] If the patient leaves before discussing the discharge plan, ensure the provider attempts to contact the patient or family by phone.
- Coordinate care with primary care or other outpatient providers within a few days, assist in scheduling tests or referrals, and provide written instructions. When indicated, provide referrals to substance use treatment or mental health counseling facilities that have low barriers to treatment after discharge, and provide written instructions.[1,6,7,20] With consent, share the care plan with the family.[7]
- Assist the patient with filling prescriptions before discharge because patients who leave AMA commonly do not fill their prescriptions.[7,20]
- Ensure follow-up on any pending tests and communicate any abnormal results to the patient.[14]
- Convey a message that the team wants the best for the patient and the patient may return for care.[14]
- Assist with housing by building strong relationships with homeless agencies to support patients' discharge.
- Ensure strong and consistent documentation of the process.[14,20]
- Avoid coercing the patient into staying by making unsubstantiated comments such as insurance will not reimburse a hospitalization if the discharge is AMA.[7]

Evaluate your organization's practices

- Conduct a gap analysis between your organization's current practices for discharging patients AMA and the leading practices described above.
- Document your organization's current rate of AMA discharges, implement interventions to decrease AMA discharge, and monitor their effect.
- Conduct discharge follow-up calls to identify the patient's reasons for leaving AMA, resolve issues and reinforce education to increase adherence to the aftercare plan.[1]
- Use the information from patient satisfaction surveys to improve care.
- Evaluate ED wait times for improvement opportunities.
- Evaluate disparities in the quality of care delivered to patients who are discharged AMA.[7]

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