Patient-Directed Discharges: Understanding Why, and How to Help

Wednesday, October 4, 2023
3:00 to 5:30 pm

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SURGE Substance Use Response Guidance and Education

- The Health Federation of Philadelphia's Perinatal Substance Use Disorder and SURGE programs
- Kristin Walker, MSN, ACRN
  Perinatal Public Health Programs Coordinator
- Caroline Drob
  SURGE Program Assistant

Department of Public Health

HEALTH FEDERATION OF PHILADELPHIA

SURGE Substance Use Response Guidance and Education

Supported by Philadelphia Department of Public Health:

- Maternal, Child, and Family Health Division
- SUPHR (Substance Use Prevention, and Harm Reduction) Division
- THANK YOU!

Department of Public Health

HEALTH FEDERATION
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Moderator:

Shoshana V. Aronowitz, PhD, MSHP, FNP-BC
Assistant Professor
Department of Family and Community Health
University of Pennsylvania School of Nursing

Patient-Directed Discharge: Introduction

Objectives:

Describe the motivating factors for patient-directed discharge.

Identify important ways to proactively plan for a self-directed discharge.

Discuss measures which may prevent patient-directed discharges.

Why the terminology change?

“Against medical advice” -- this language is stigmatizing

De-emphasizes the reasons why patients choose to disengage from healthcare

Turns a systemic problem into a personal failure

Places blame on patients who might be receiving suboptimal care

“…the ‘against’ component of the AMA designation implicitly describes an antagonistic interaction between patients and clinicians rather than encouraging a collaborative approach to promoting patient health when these situations arise.” (Kleinman, Brothers, Morris 2022)

Kleinman, R. A., Brothers, T. D., & Morris, N. P. (2022). Retiring the "Against Medical Advice" Discharge. Annals of internal medicine, 175(12), 1761–1762. https://doi.org/10.7326/M22-2964

“If you come here a couple times and you’re known on the records as you’re a drug addict or you’re an alcoholic or whatever, then they label you, and they don’t give you the care that you normally should receive.”

Simon, R., Snow, R., & Wakeman, S. (2020). Understanding why patients with substance use disorders leave the hospital against medical advice: A qualitative study. Substance abuse, 41(4), 519–525. https://doi.org/10.1080/08897077.2019.1671942

PROGRAM

- Dr. Kara Pavone: Epidemiology and motivating factors for PDD
- Caroline Darlington & Dr. Laura Hart: Factors related to postpartum PDD
- Melissa Fryling & Brad Meck: Perspective of those with lived experience
- Dr. Raagini Jawa: Perspective of a hospital clinician
- Dr. Joseph D'Orazio: What has helped, what can be better
- Rachel Neuschatz: Wound care
- Abby Brennan: Additional factors
- Caroline Darlington: What helps postpartum
- Nicole O'Donnell: Certified recovery specialist perspective

Patient-Directed Discharge

Kara J. Pavone, PhD, RN

University of Rhode Island, College of Nursing

October 3, 2023

Hospitalization

The goal of hospitalization is to provide comprehensive, specialized, and effective medical care to improve or maintain a patient's health and well-being.

Hospitalized Patients Who Use Drugs

The prevalence of OUD has increased substantially over the last two decades, but the implementation of hospital-based interventions for these patients has only recently come into the forefront.

Hospital Discharge

An effective hospital discharge optimizes a patient’s ongoing care as they transition out of the hospital to the home or an outpatient care facility environment.

Consequences of Discontinued Care

- Worsening of Medical Condition
- Increased Risk of Complications
- Hospital Readmission
- Chronic Health Problems
- Reduced Quality of Life
- Pain and Suffering
- Financial Costs
- Psychological and Emotional Impact
- Legal and Ethical Issues

Patient-Directed Discharge

Occurs when an individual chooses to leave the hospital before the treatment team recommends discharge.

- Discharge against medical advice (AMA)
- Voluntary discharge
- Discharge with informed refusal
- Patient declined further treatment after informed consent
- Self-directed discharge

Prevalence and Impact of Patient-Directed Discharge

CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE®

Burden of 30-Day Readmissions Associated With Discharge Against Medical Advice Among Inpatients in the United States

Nilay Kumar, MD

University of Wisconsin School of Medicine and Public Health, Madison.

Compton et al. Harm Reduction Journal (2021) 18:131
https://doi.org/10.1186/s12954-021-00581-6

Harm Reduction Journal

RESEARCH

Open Access

Acute pain and self-directed discharge among hospitalized patients with opioid-related diagnoses: a cohort study

Peggy Compton[1*], Shoshana V. Aronowitz[1], Heather Klusaritz[2] and Evan Anderson[1]

Case study #2

Patient was admitted to a general acute care hospital 20 times during the first 9 months of 2017, three times through urgent care and the remainder through the emergency room. Seventeen of the admissions resulted in a self-directed discharge, with lengths of stay for those discharges ranging from 0 to 13 days. The patient had an opioid dependence diagnosis, and one admission was related to overdose; the patient was also diagnosed with cocaine use disorder and nicotine dependence. All but one admission was for a painful condition. Admitting diagnoses progressed from cellulitis of the left (×8) and right (×2) upper limb, to extradural and subdural abscess (×2), to intraspinal abscess and granuloma (×1), to sepsis due to methicillin resistant Staphylococcus aureus (×2). The patient's course was complicated by insulin-dependent Type 2 diabetes with hyperglycemia, and two admissions were related to open wounds and chronic skin ulcers. Procedures administered included superior vena cava infusion and drainage of the intracranial epidural space and of the buttock. On several admissions, anxiety disorder and major depressive disorder were identified. One admission also related directly to a fall. This patient had Medicaid insurance coverage and total costs associated with hospitalization was $871,666.50.

Vulnerability to Patient Directed Discharge

- Young adults
- Substance use disorder
- Mental health issues
- Limited health literacy
- Socioeconomic factors
- Patients with frequent hospitalizations

SAMHSA ADVISORY

Substance Abuse and Mental Health Services Administration

MAY 2023

EVIDENCE-BASED, WHOLE-PERSON CARE FOR PREGNANT PEOPLE WHO HAVE OPIOID USE DISORDER

An Integrative Review of Factors Related to Self-Directed Discharge among People who Use Opioid Drugs

Factors Contributing to Patient-Directed Discharge

- Patient Characteristics
- Symptom Management
- Environmental Factors
- Protective Factors

Patient Characteristics

- Age
- Sex
- Race
- History of mental or chronic illness
- History of polysubstance use
- Housing and insurance status

Symptom Management

“If you were experiencing pain or if you were going through withdrawal in the hospital, they're not willing to give you methadone… I got so sick that I had to leave the hospital. It was just madness.” – 42-year-old man

Environmental Factors

“I was getting my blood taken one time and I was like, “Ow, that hurts.” And the nurse was like, “Well, don’t you do this for fun?”

Protective Factors

“I’ve been here, unfortunately, oh, I would say, twenty times. And I’ve always been treated extremely kind. Everybody’s been extremely professional, extremely kind, very caring, understanding, and nonjudgmental.”

Conclusions

All patients, regardless of history of drug use, deserve equitable care.

Postpartum Self-Directed Discharges

Caroline Darlington, MSN, WHNP-BC

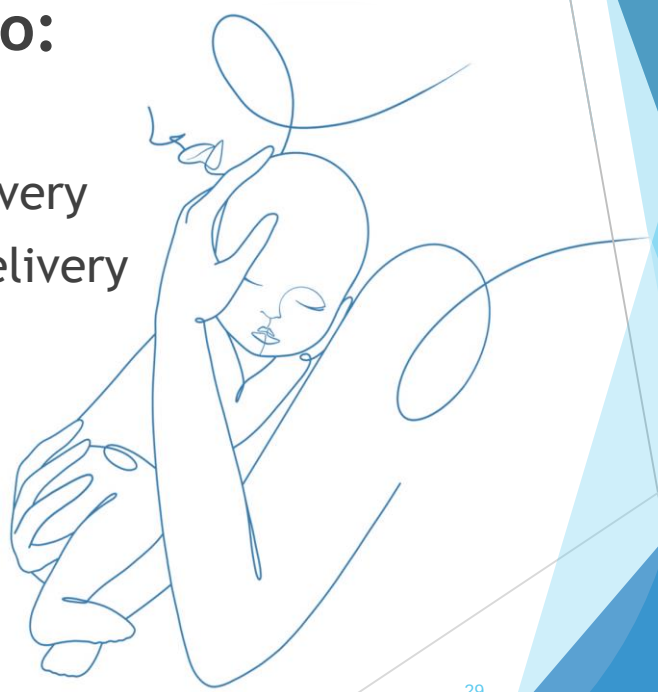
Jefferson Abington Hospital

Nursing PhD Student

University of Pennsylvania School of Nursing

Postpartum Self-Directed Discharges

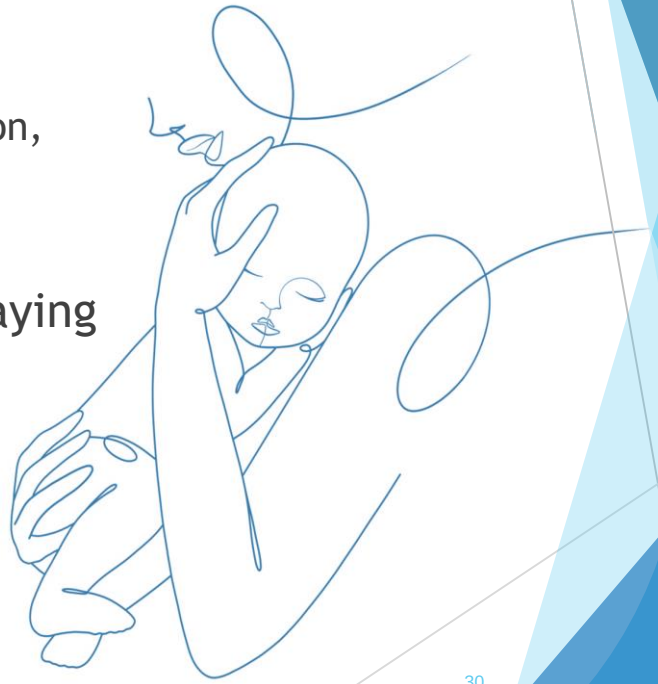
- **Relatively uncommon due to:**
  - Shorter inpatient stays
    - *Vaginal birth*: 1-2 days post-delivery
    - *Cesarean birth*: 2-4 days post-delivery
  - Baby-dependent factors
    - Infant's discharge timing
    - Child Protective Service (CPS) implications of SDD



Postpartum Self-Directed Discharges

Contributing Factors

- No infant rooming-in with patient
  - NICU admission, fetal demise, adoption, CPS removal
- Childcare concerns
- Acute maternal complications delaying anticipated discharge day
- Pain, withdrawal, or MOUD issues
- Poor/inconsistent communication
- Medical mistrust & legal issues
- “Double” stigma of maternal SUD



Perspective of persons with lived experience

- Melissa Fryling
- Brad Meck

Provider perspectives of PDD

Raagini Jawa MD, MPH, FASAM
Infectious Disease-Addiction Medicine, Asst Professor of Medicine
Center for Research on Healthcare, University of Pittsburgh
Clinical Harm Reduction Specialist, Grayken Center for Addiction

rjawa@pitt.edu

www.healthfederation.org

Provider perspectives of PDD

- Frustration for system barriers that are at odds of providing empathetic and evidence-based care
- Potential for compassion fatigue and burnout
- Fear of eroding patient-provider relationships and provider-provider relationships
- Acknowledge the critical gap in universal harm reduction, addiction med, and stigma education for ALL hospital staff and providers

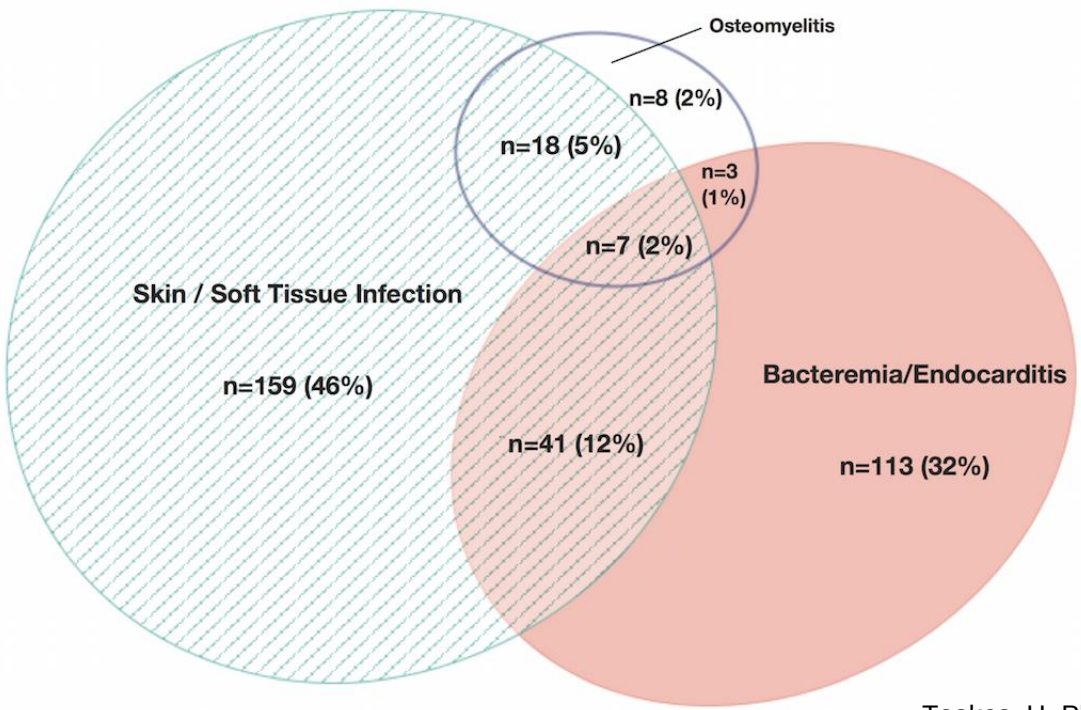
Image credit: www.314e.com

Health System Contributors

- Multiple specialist teams, team members, and provider turnover impacts patient-provider trust
- Nonuniformity with addiction-friendly teams and staff
- Lack of 24 hour access to addiction consultants
- Stigmatizing hospital protocols:
  - Hospital security room searches or Patient pat-downs
  - 24-hour in-room video or sitter monitoring
  - Searching or prohibiting visitors
  - Lower barrier to “discharge patients”
  - Forced UDS or pulling of PICCs
- Long and isolating hospital stays

Pollini et al. IJDP 2021

Frequency of infectious diagnosis among hospitalized PWID



Tookes, H. PlosOne 2015

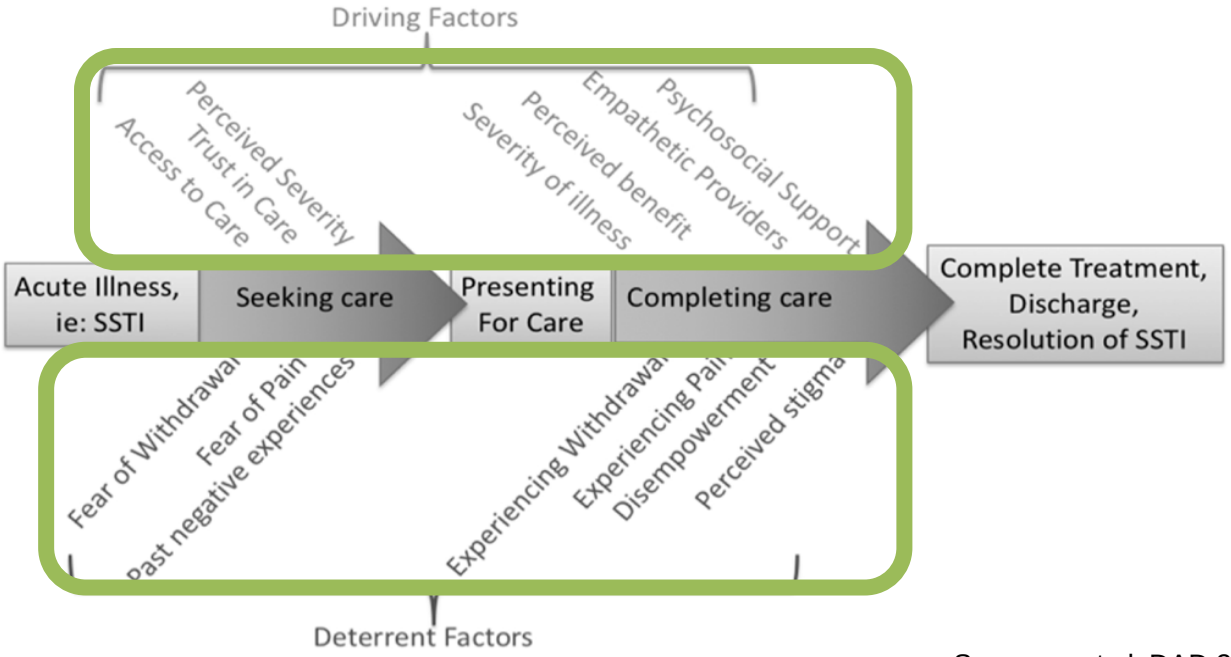
Reasons for PDD among PWID who had SSTIs

Reasons for leaving hospital against medical advice	N	n (%)
Judgment or mistreatment	43	23 (54%)
Withdrawal concerns	43	23 (54%)
Pain control concerns	43	17 (40%)
Ambivalence about treatment	43	14 (33%)
Time commitment concerns	43	8 (19%)
Legal concerns	43	3 (7%)
Logistic concerns	43	2 (5%)
Fear of procedure	43	2 (5%)

*Percentages do not sum to equal 100%, as the responses were not mutually exclusive.

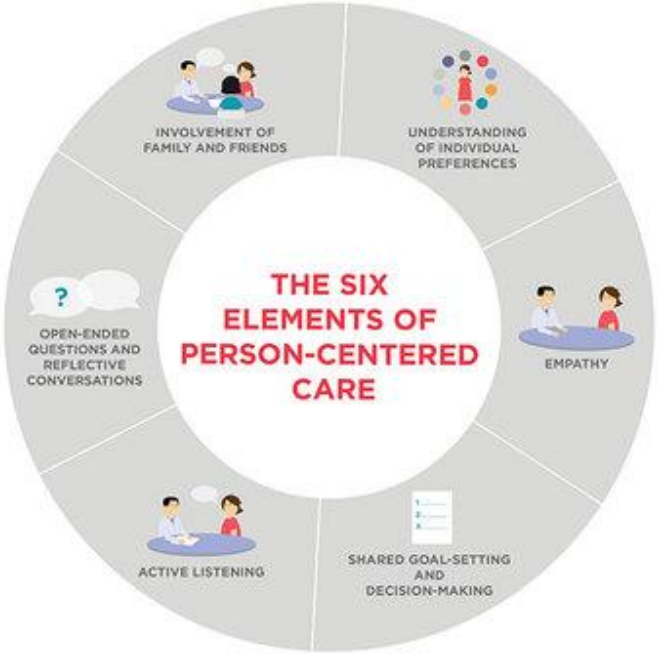
Summers et al. DAD 2018

Conceptual model for care seeking behaviors among PWID



Summers et al. DAD 2018.

Providers have many opportunities to mitigate PDD



and it requires all hands on deck approach

Image credit: https://idainstitute.com/

5 MINUTE BREAK

HEALTH FEDERATION
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Patient Directed Discharge

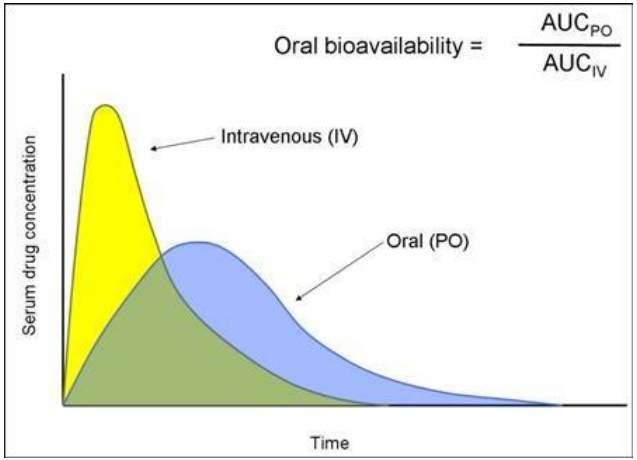
Joseph D'Orazio, MD
Addiction Medicine
Cooper Center for Healing
Cooper University Hospital

Creating Effective Care Plans

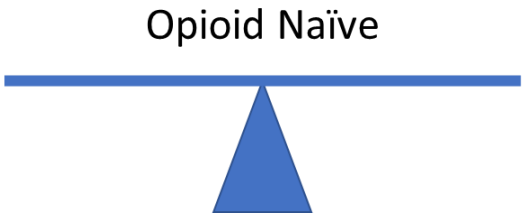
- Building trust and patient-provider relationships
  - Effective communication
  - Validate → empathize → plan
- Shared care plans
- Patient autonomy
  - Individualized plans > stock treatment plans
- Comprehensive Care
  - Seemingly minor issues: food, tv, books, music, play

Effective Evaluation and Treatment of Opioid Withdrawal

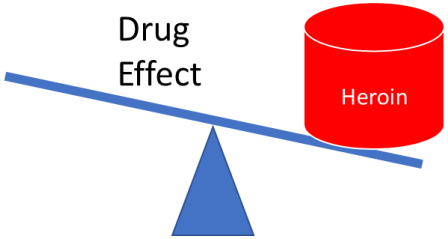
- COWS
- Evaluate dependence prior to admission and compare with current treatment
  - Subtherapeutic dosing
  - Patient self-medicating during admission
  - Short-acting IV medication for immediate results
- Re-evaluate need to adjust overall regimen
  - Switch from buprenorphine to methadone?
  - Increase long-acting opioid dose - Withdrawal
  - Increase short-acting dose - Pain



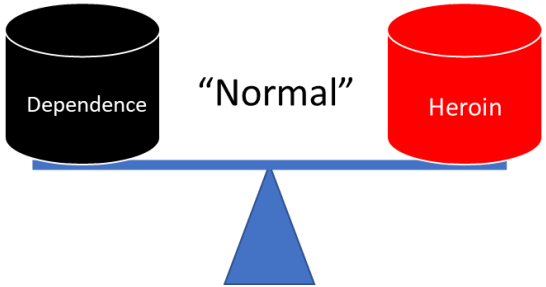
1.


Opioid Naïve

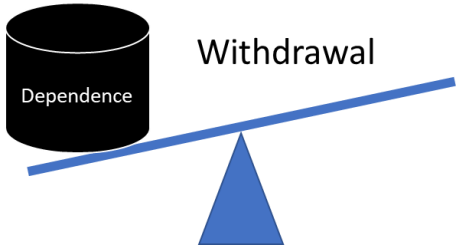
2.


Drug
Effect
Heroin

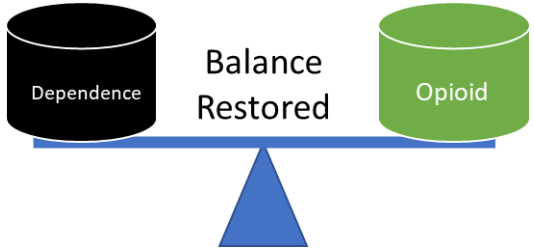
3.


Dependence
"Normal"
Heroin

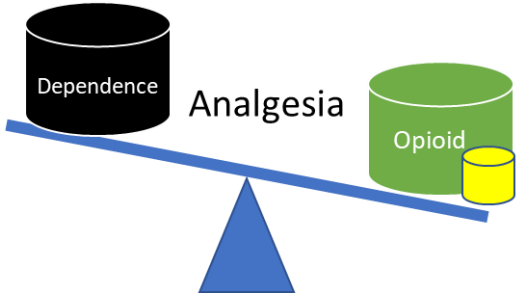
4.


Dependence
Withdrawal

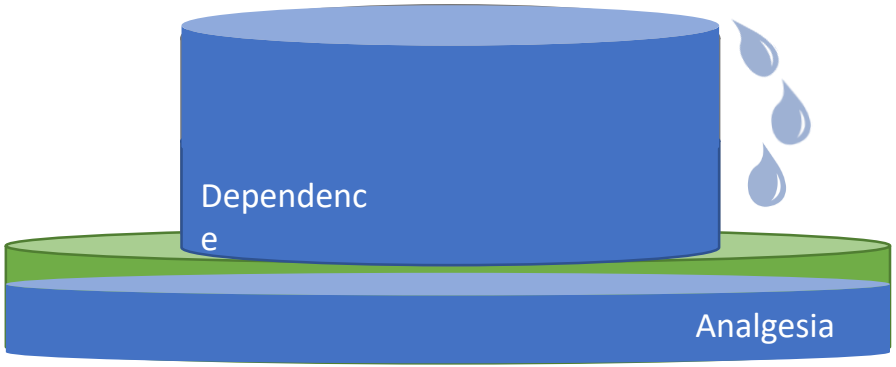
5.


Dependence
Balance
Restored
Opioid

6.

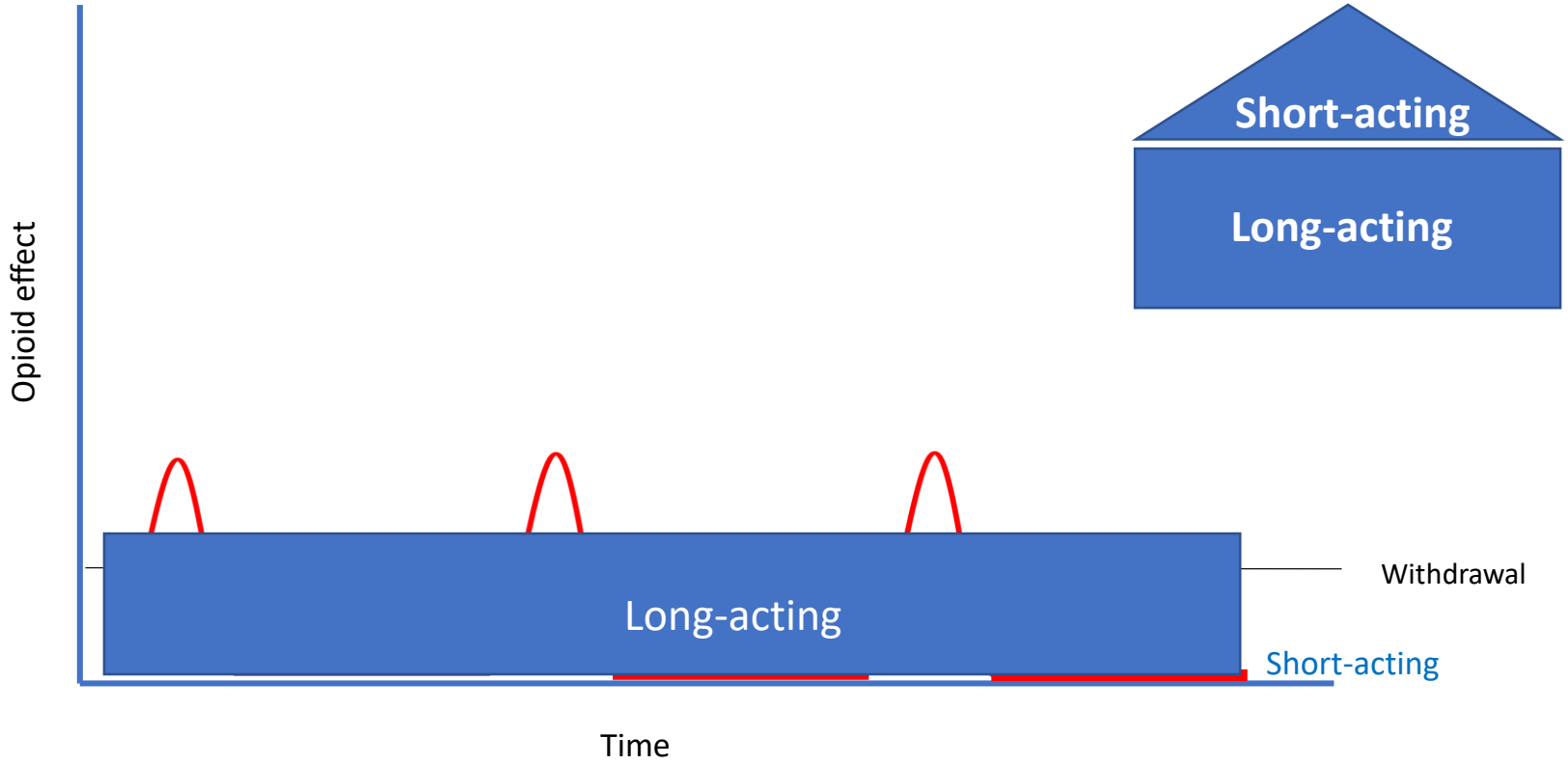

Dependence
Analgesia
Opioid

Pain Control in the Setting of Severe Opioid Tolerance/Dependence: Overflow the Bucket



- Basal/bolus approach
  - Long-acting/continuous infusion opioids for management of dependence
  - Short-acting opioids to provide analgesia
- Long-acting opioids
  - Methadone, buprenorphine, oxycodone ER, hydromorphone continuous infusion…
- Short-acting opioids
  - Oxycodone, hydromorphone, morphine…

Pain Control in the Setting of Opioid Dependence



Typical Treatment Plan Changes

- Withdrawal→ add long-acting (“Fill the bucket” to manage dependence)
- Pain→ increase short-acting dosing
  - Oxycodone 30mg PO Q4 PRN mild/mod/severe pain/withdrawal
  - Hydromorphone 2mg IV Q3 PRN breakthrough pain/withdrawal
- Seemingly maximized therapy → add hydromorphone PCA pump
  - Basal rate equivalent to long-acting for withdrawal management
    - Hydromorphone 1mg/hr basal equivalent to oxycodone ER 100mg Q8 or methadone 40mg daily
  - Bolus dose to supplant PRN dosing
    - Hydromorphone 0.5mg Q10mins → 1mg Q15mins
- Non-opioid receptor agonists
  - Multimodal pain control, Adjunct withdrawal meds, Benzodiazepines, Ketamine, Antipsychotics…

MME per Day Comparison of Opioids

Bag of Philadelphia Heroin/Fentanyl/Xylazine:
~ fentanyl 5000mcg

Equivalent to:
hydromorphone 75mg IV
oxycodone 1000mg

Contingency Planning

- Create for plan for patient-directed discharge and reevaluate frequently
  - **Management**
    - X medication for X complaint, first steps, next steps
  - **Outpatient Medications**
    - IV to PO antibiotics recs
    - “Attending will Rx medication X to the hospital pharmacy in the AM”
  - **Follow-up care**
    - Walk-in clinic options
    - Best contact to make appointment after leaving if not able to make appointment immediately at discharge (off hours)

AMA Threat = Cry for Help

"He keeps asking for more opioids; he's just a drug seeker"

"Why bother? He's just going to get up and leave when he's in withdrawal anyway."

Patient left AMA without signing papers. States he is leaving to "get high."

Patient states if "you're not going to give me anything strong enough, I'm just going to get up and leave."

Crisis Management

- Prefrontal cortex damage and response to stress
- Assess capacity (competence is a legal state, physicians determine capacity)
- Assess risk for suicide or homicide

- Keep the DSM-V Criteria of Opioid Use Disorder in mind
  - “Explained the risk of returning to use and not completing medical care…”
- Assess concerns, validate, empathize, troubleshoot, provide ongoing support, plan
- Evaluate imminent risk while creating plan
  - Highest risk: all the resources to keep patient inpatient
  - Lowest risk: consider alternative plan as outpatient

Use of Substances During Inpatient Stay

- Typical response that leads to a PDD
  - Words used during response to use/overdose
  - Security and police involvement
  - Person and belonging search
  - Placing belongings with security
  - Visitor restriction
- Create guidelines to respond to use in the hospital
  - Avoid punitive measures
  - Concentrate on safety and support

Inpatient Treatment of Anxiety

- Undiagnosed/untreated/unmasked anxiety disorder
  - Previously masked by substances
- Initiate anxiety treatment during hospitalization
- Hospitals are particularly anxiety provoking environments

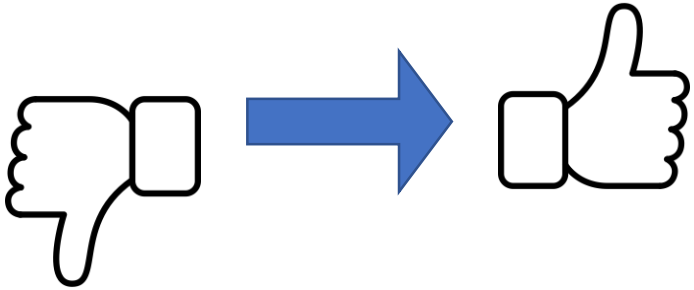
- Non-medication interventions
- Abortive agents for anxiety attack
  - Benzodiazepines, Antihistamines
- Preventative agents
  - SSRI/SNRIs, Buspirone, TCA's, Antipsychotics

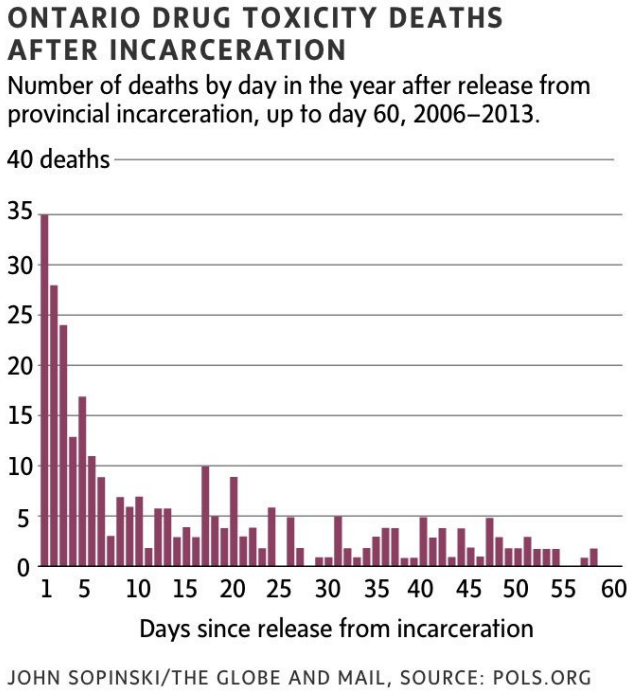
What to do when you cannot recover care?

- Refer to contingency plans
- Create new/next best care plan with patient to help mitigate the risk of a bad outcome
  - Medications, follow-up care, return to the hospital plan
- Provide welcoming environment to return instead of restrictive
  - “What could we do to make things better for you upon returning?”
- Document a care plan for the next provider
  - Medication dosing and timing, what didn’t work, what did work
  - Major hurdles that led to patient-directed discharge to avoid

Detox

Opioid Maintenance





- Patients with OUD returning to unstable environments with a decreased tolerance to opioids have higher risk of fatal overdose
- Tolerance is a protective mechanism from overdose

Patients Not Interested in Recovery

- Avoid tapering off opioids
  - Return to use puts patients at higher risk for overdose death
  - Adding methadone 40mg daily at a minimum
  - No need to Rx meds if patient has identified plan to return to use at discharge

https://www.emra.org/emresident/article/lit-review-ama-discharge

Administration & Operations, Admin Ops Literature Review

Against-Medical-Advice Discharges from the ED: Literature and Strategies Review

12/17/2020 Clinton Lam , Jared Ditkowsky, MD , Vineet Kumar Sharma, MD, MS , Nicholas Stark, MD, MBA

Topics:

Ethics Seminars: A Best-practice Approach to Navigating the Against-Medical-Advice Discharge

The Importance of a Proper Against-Medical-Advice (AMA) Discharge: How Signing Out AMA May Create Significant Liability Protection for Providers

Risk: Patients Who Leave the Emergency Department Against-Medical-Advice

Financial Responsibility of Hospitalized Patients Who Left Against-Medical-Advice: Medical Urban Legend?

https://www.emra.org/emresident/article/lit-review-ama-discharge

Summary of Literature

Despite the fact that AMA discharges are a common phenomenon, accounting for approximately 500,000 discharges on an annual basis in the U.S., there is an abundance of misconceptions and knowledge gaps in the medical community.[1-4] Although patients may be partly at fault for adverse outcomes if they leave AMA, providers may still be held liable. However, if the provider determines capacity, discloses risks, and properly documents the AMA discharge, they may obtain significant liability protection in the event of litigation.[5] Furthermore, there is a common counseling practice of informing patients that their insurance will not reimburse them if they leave AMA, which by empirical analysis appears to be a false claim. Additionally, patients who leave the ED AMA are more likely to miss follow-up appointments and not fill prescriptions and suffer from significant pathology for which they may be reluctant to return.[23-24]

AMA discharges present complex professional and ethical problems that ultimately compromise patient safety and situates providers in high-risk dilemmas. In these scenarios, it may be beneficial to adhere to systematic best-practice strategies. By following AIMED frameworks, providers can uphold professional and ethical standards while reducing the risk of legal ramifications to themselves.[22] To adequately address the escalating number of AMA discharges nationwide, focused efforts must identify risk factors and vulnerable populations, including those with comorbidities, psychiatric illnesses, and substance abuse disorders.

Academic Emergency Medicine
Official Journal of the Society for Academic Emergency Medicine

ETHICS SEMINAR

Ethics Seminars: A Best-practice Approach to Navigating the Against-Medical-Advice Discharge

Mark A. Clark, MD, Jean T. Abbott, MD, MH, and Tara Adyanthaya, JD, MBE

The authors highlight the complex medicolegal and ethical challenges presented to physicians in the case of an AMA discharge, including balancing patient autonomy and harm prevention. They advocate for a practical, systematic approach AIMED (Assess, Investigate, Mitigate, Explain, and Document)

Assess	• Severity of illness/urgency of treatment • Decision-making capacity (treat underlying cause if impaired) • Degree of risk to patient's health and welfare
Investigate	• Patient's reason for leaving • Comfort (symptom management) • Communication regarding care plan • Withdrawal syndromes • Pressing responsibilities like child, elder, or pet care issues • Allies such as primary care provider or family member
Mitigate	• Offer maximal necessary treatment acceptable to patient • Provide prescriptions for medications as indicated • Provide optimal follow-up plan and discharge instructions
Explain	• Original treatment plan risks and benefits • Specific dangers of failing to follow proposed plan • Alternative plan • Discharge instructions including reasons to return • That the patient is welcome to return at any time
Document	• Medical screening exam • Decision-making capacity assessment • Discussion of initial treatment offered • Discussion of patient refusal and reasoning • Efforts to negotiate, recruit family/friends • Alternative plan with risks and benefits • Discharge instructions including when to return • Efforts to locate if no discharge conversation occurred

THE Hospitalist

An Official Publication of shm Society of Hospital Medicine

Patient Care

What Are Best Practices for Patients Discharged against Medical Advice?

By Eric R. Goodman, MD; Sri Lekha Tummalapalli, MD

January 27, 2016

Key Points

- Patients discharged against medical advice are a vulnerable patient population and suffer increased morbidity and mortality, healthcare costs, and rates of readmission.
- AMA patients are clinically, demographically, and psychosocially heterogeneous.
- Shared decision making between patients and providers may allow for harm reduction in discharge planning and may obviate the need to discharge certain patients AMA.
- Further research is needed to better understand current practice patterns and to identify evidence-based strategies for safe discharge planning in the AMA population.

THE Hospitalist

An Official Publication of shm Society of Hospital Medicine

Patient Care

What Are Best Practices for Patients Discharged against Medical Advice?

By Eric R. Goodman, MD; Sri Lekha Tummalapalli, MD

January 27, 2016

- Patients discharged AMA are a diverse population at markedly increased risk of morbidity, readmissions, and subsequent healthcare cost. We argue that in all cases of a potential premature discharge, a collaborative and patient-centered approach is crucial. Such an approach allows the provider to identify and address the patient's concerns regarding further inpatient care, to explore possible safe outpatient treatment options, to document patient capacity, and to provide appropriate harm-reduction measures such as prescriptions.
- Further research into the current practice patterns of hospitalists and other providers is necessary to allow for the formulation and adoption of best practices and implementation of appropriate harm-reduction strategies. – The Hospitalist

Take-Home Points

- Approximately 1-2% of hospital discharges occur AMA. Patients who leave AMA have significantly higher readmission rates and may be at increased risk of serious adverse health consequences when compared with normally discharged patients.

- The use of a standardized protocol to address issues of decision-making capacity, follow-up arrangements, and communication may help reduce the risk of errors when patients are discharged AMA.

- Discharge AMA does not absolve the physician of responsibility for poor outcomes; as always, good clinical care and careful documentation are of paramount importance.

Discharge Against Medical Advice

Stephen W. Hwang, MD, MPH | May 1, 2005

Table. Important Steps When a Patient Is Leaving Against Medical Advice

Issues	Specific Actions
Decision-making capacity	• Assess the patient's decision-making capacity • Document the capacity assessment in the chart • Document the discussion with the patient regarding the severity of the patient's illness and the potential consequences of leaving AMA
Follow-up arrangements	• Discuss specific scenarios with the patient that should prompt an immediate return to the emergency department • Arrange for telephone follow-up, if indicated • Arrange for home care, if indicated • Arrange for an outpatient follow-up appointment (preferably within the next 7 days) • Provide prescriptions for any new medications (arrange for dispensing of medications to the patient, if possible) • Document the above in the chart
Communication	• Provide the patient with a brief written summary of his or her diagnoses, treatments, medications, and follow-up plans • Immediately inform the patient's primary medical team regarding discharge AMA and follow-up plans • Communicate with the patient's primary care provider (if different from the inpatient medical team) regarding discharge AMA and follow-up plans • With the patient's consent, communicate with the patient's next-of-kin regarding discharge AMA and follow-up plans • Document the above in the chart

THE SULLIVAN GROUP

BLOG & ARTICLES

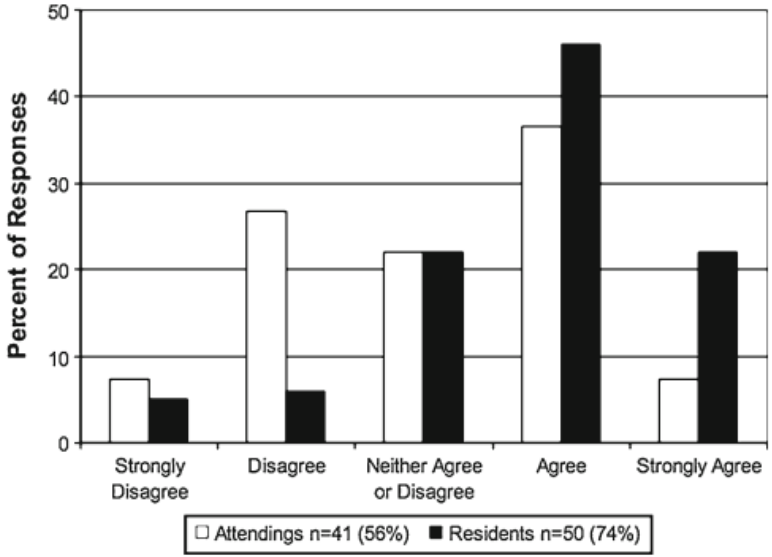
Do's & Don'ts of AMA: Patients Who Leave Against Medical Advice

As a guide to the AMA process, consider the following list of **Do's and Don'ts**:

- **Don't** ignore the patient who wants to leave AMA. If at all possible, stop what you are doing and prepare to address the issue.
- **Do** determine the decision-making capacity of the patient. Do they comprehend the information and consequences and understand the risks and benefits of the options, and can they communicate these back to you?
- **Don't** blame or berate the patient or anyone else for their desire to leave.
- **Do** apologize if the patient has been waiting or if there have been delays in the patient care process. Apologies are free. Lawsuits cost millions.
- **Don't** just ask the nurse to have the patient sign a generic AMA form and leave. This course of action provides little protection for the practitioner.
- **Do** enlist the patient's family and friends in your attempt to convince the patient to stay.
- **Don't** express your frustration and anger to the patient. Instead, earnestly convince them that your overriding interest is their well-being. Make sure they know that you are on their side against a potential threat to their health.
- **Do** document the patient's "informed refusal" of crucial diagnostic testing (e.g., blood work or X-rays), procedures (e.g., LP to rule out meningitis or subarachnoid hemorrhage), or treatments (e.g., medications or transfusions) in the same detail as you would an AMA.
- **Don't** refuse to provide treatment; this could be considered abandoning the patient. Provide whatever treatment, prescriptions, follow-up appointments, and specific discharge instructions the patient will accept.
- **Do** document the details of the AMA patient encounter in the patient's chart (see samples below). Include documentation of the patient's decision-making capacity, the specific benefits of your proposed treatment and risk of leaving AMA, what you did to get the patient to stay, and your compassionate interest in having the patient return for any reason. Have the patient sign an AMA form that addresses these details, witnessed by a family member and/or staff member.
- **Don't** worry about whether or not the patient's insurance will deny payment if they sign out AMA. Their insurance is not your problem, but a malpractice suit will definitely be your problem.

Financial Responsibility of Hospitalized Patients Who Left Against Medical Advice: Medical Urban Legend?

Gabrielle R. Schaefer, BA[1], Heidi Matus, MD[2], John H. Schumann, MD[3], Keith Sauter, BA[4], Benjamin Vekhter, PhD[5], David O. Meltzer, MD, PhD[5], and Vineet M. Arora, MD, MAPP[2,5]



The authors conducted a retrospective cohort study of hospitalized patients from 2001 to 2010 and a cross-sectional survey examining physician beliefs and counseling practices regarding AMA discharges. It was discovered that there were **zero cases of payment refusal** that could be attributed to the AMA discharge itself. The authors argue it is crucial not to deny patients the autonomy to make their own decisions.

Figure 1. Percentage of Physicians Who Believe Patients are Held Financially Responsible When They Leave AMA (difference between attending and resident responses analyzed using Wilcoxon Rank Sum test, showing residents agreed more strongly that patients are held financially responsible, $p<0.004$).

Schaefer GR, Matus H, Schumann JH, et al. Financial responsibility of hospitalized patients who left against medical advice: medical urban legend?. *J Gen Intern Med*. 2012;27(7):825-830

Wound-Related Factors
Of Incomplete Hospital Stays

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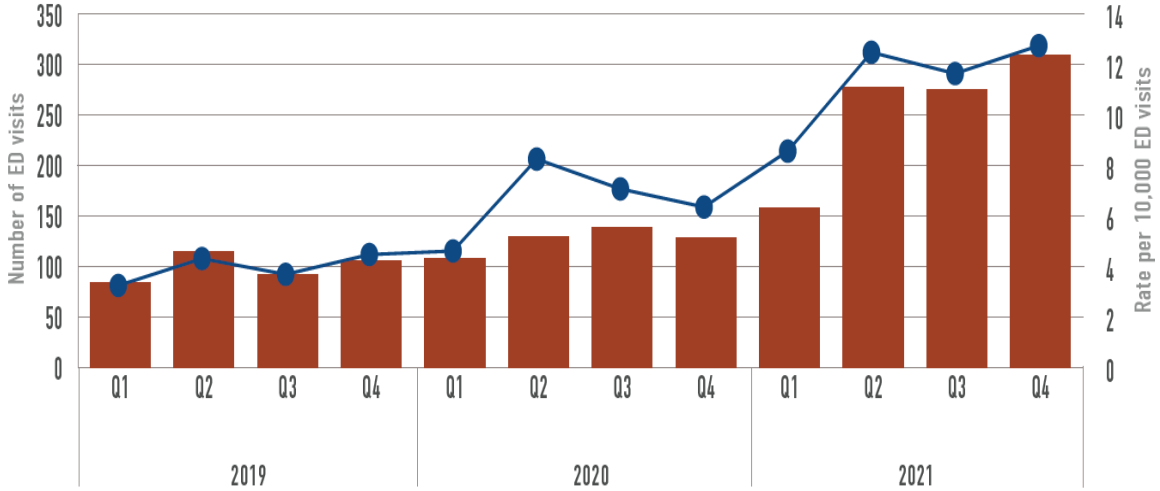
Division of Substance Use Prevention & Harm Reduction

More + worse xylazine-associated wounds => More people with SUD accessing hospital care

For:

- Tx local, systemic infection (incl. I&Ds, IV antibiotics)
- Tx sequalae of chronic/untxed open wound, infection
- Surgical debridement
- Skin grafting, amputation
- Medical clearance or referral to L4 for detox/rehab

ED visits for skin and soft tissue infections by quarter
(source: PDPH Syndromic Surveillance System)



Data Source: Philadelphia Department of Public Health Syndromic Surveillance System

Wound-related Patient Concerns
Impacting Incomplete Hospital Stays

- **Staff stigma** related to wound odor, drainage, need for ADL assistance (in addition to SUD/etc.)
  - In attitude, verbal and body language, avoiding entering room
  - Withholding care including bathing/toileting, wound dressings/changes, PRN medication
- **Pain management** related to wounds, dressing changes, bedside procedures
  - Not offered premedication, not given time to take effect
- **Information, informed consent**: ‘They didn’t really tell me anything’
  - Incomplete/ineffective inclusion of patient in care plan, including for surgical amputation

Community Clinician Concerns
With Incomplete Hospital Stays

- No discharge medications provided (including oral antibiotics)
- No dressing supplies provided and/or no dressing provided inpatient
- No follow up care discussed
- No discharge teaching provided
- No discharge paperwork
- Rare but we’re working on it: Hospital-to-community care team-to-care team report, including information that patient left prior to receiving

Potential for Growth
In the Hospital

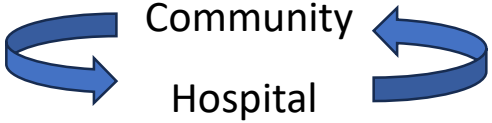
- **Humanizing care, at minimum**
  - Anti-stigma and wound-specific staff training/education (CAMP Trang Wound Care Pearls)
  - Advocacy for staffing and other resource
- **Responsive, multi-modal pain/withdrawal management** informed by drug testing
  - Premedication with adequate time to achieve effect despite tolerance and hyperalgesia
  - Atraumatic dressing selection, wound cleansing, and dressing removal technique
- **Robust, responsive informed consent** and collaborative trauma-informed care
  - Mindful of health literacy, learning style, trauma response, medication
- **Anticipate atypical, early discharge**
  - Prep and place at bedside as early as possible: discharge dressing change supplies, community follow-up information, patient education, discharge meds/oral antibiotics

Potential for Growth
Between Hospital and Community

- **Care coordination and advocacy** between community clinical/wound care providers and hospitals
  - Protocols and partnerships forming with inpatient teams: Addiction med, CRS/peers, SW/CM
  - Need for communication at ED entry, through inpatient admission, and at formal or informal discharge
- **Information sharing** in groups and meetings
  - Citywide Hospital Working Group, Wound Care Collab, Mobile Units Collab
  - Wound/SSTI Morbidity and Mortality Review—guidance forthcoming

For people and populations with medical setting trauma and at high risk for experiencing stigma,

A complete hospital stay starts and ends with community care



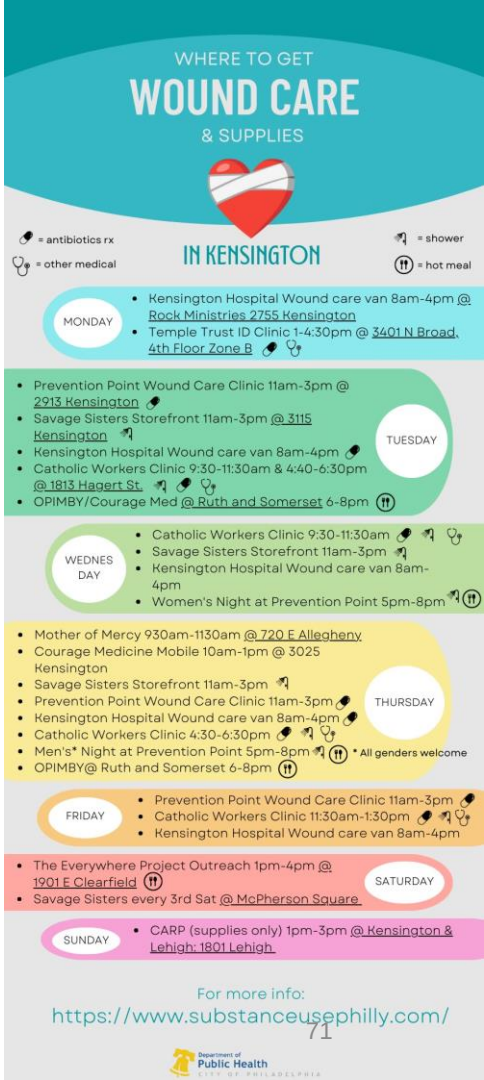
Community-hospital collaborations to coordinate care:

Bidirectional communication

Information sharing, report

Relationship, advocacy

Improved outcome & experience for patient, clinician



Patient Directed Discharge - Other Factors that Help

Presented by Abby Brennan, BSN, RN, CARN

Quick evaluation & treatment of withdrawal

OB triage acuity tool updated to include SUD care

New protocol for efficient initiation of MOUD

Admission workflow defined for quick assessment by RN - **avoid waiting without assessment and avoid withdrawal without treatment**

New admission question - “are you concerned you may withdraw from any substances like alcohol, nicotine, or other substances while in the hospital?”
“Yes” triggers addiction consult service

Boston Medical Center OB Triage Acuity Tool

5/1/23

All Patients evaluated by an RN within 10 minutes of arrival

Emergent Acuity 1

Provider & RN to see patient immediately

Abnormal Vital Signs
- Maternal HR < 40 or > 130
- Apneic
- SpO2 < 93%
- SBP ≥ 160 or DBP > 110 or < 60/palpable
- No FHR detected by doppler (unless previously diagnosed fetal demise)
- FHR < 110 bpm for > 60 seconds

Maternal Conditions Requiring Immediate Life Interventions
- Cardiac Compromise
- Severe Respiratory Distress
- Chest Pain
- Hemorrhaging
- Seizing
- Acute mental status change or unresponsive (cannot follow verbal commands)
- Signs of placental abruption
- Signs of uterine rupture
- Opioid overdose event
- Opioid withdrawal COWS > 30 (severe)
- Alcohol Intoxication withdrawal CIWA > 19 (severe)

Fetal Conditions Requiring Immediate Life Interventions
- Prolapsed cord

Imminent Birth
- Fetal parts visible at the perineum
- Active maternal bearing-down efforts

Urgent Acuity 2

Provider to see patient within 30 minutes

Abnormal Vital Signs
- Maternal HR > 120 or < 50
- RR > 26 or < 12
- Temperature ≥ 101.0º F (38.3º C)
- SpO2 < 95%
- SBP ≥ 140 or DBP ≥ 90 symptomatic, or SBP < 80 or DBP < 40, repeated
- FHR > 160 for > 60 sec; decelerations

Severe Pain (unrelated to contractions) ≥ 7 on a 0-10 pain scale

Maternal Conditions Requiring Urgent Attention:
- Unstable, high risk medical conditions
- Difficulty breathing
- Altered mental status
- Suicidal or homicidal
- < 34 weeks with:
  - c/o or detectable contractions, cramping, backache
  - c/o SROM/leaking or spotting
- Active vaginal bleeding (not spotting or bloody show)
- c/o decreased fetal movement
- Recent trauma (fall, MVA)
- Opioid withdrawal COWS 21-30 (moderately severe)
- Alcohol Intoxication withdrawal CIWA > 9-18 (moderately severe)

≥ 34 weeks with Regular Contractions or ROM/leaking with any of these:
- HIV+
- Planned, medically indicated C/S
- Breech or other malpresentation
- Multiple gestation
- Placenta previa

Transfer of Care Needed
- Clinical needs of patient and/or newborn indicate transfer of care

Prompt Acuity 3

Provider to see patient within 45 minutes

Abnormal Vital Signs
- Temperature > 100.4º F (38.0º C)
- SBP ≥ 140 or DBP ≥ 90 asymptomatic
- Non-reactive NST

Maternal Conditions Requiring Prompt Attention:
- 34 - 36 6/7 wks with:
  - early labor signs
  - c/o SROM/leaking
- ≥ 34 weeks with:
  - Signs of active labor
  - Regular contractions and HSV lesion
  - Planned, elective, repeat C/S with regular contractions
  - Multiple gestation with irregular contractions
- Not coping per Coping with Labor Algorithm
- Opioid withdrawal COWS 11-12 (moderate)
- Alcohol Intoxication withdrawal CIWA > 4-8 (moderate)

Non-Urgent Acuity 4

Provider to see patient within 60 minutes

Non-Urgent Attention, such as:
- ≥ 37 weeks with early labor signs and/or c/o SROM/leaking
- Non-urgent symptoms may include:
  - Common discomforts of pregnancy
  - Vaginal discharge
  - Constipation
  - Ligament Pain
  - Nausea
  - Anxiety
  - Insomnia
- Opioid withdrawal COWS 5-10 (mild)
- Alcohol Intoxication withdrawal CIWA > 0-3 (mild)

Scheduled/ Requesting Acuity 5

Provider to see patient within 90 minutes

Requesting a Service, such as:
- Prescription refill
- Outpatient service that was missed

Scheduled Procedure without any complaints:
- Cesarean section
- Induction of labor
- External cephalic version
- Blood pressure check
- NST
- Ultrasound
- Routine follow up incision check
- Injections (betamethasone)

No established prenatal care
- After clinic hours (8am-4pm)

PAGING:
Acuity 1 EMERGENT page 147147*
Acuity 2-5 page 3366**** (when there is no scheduled Triage provider)

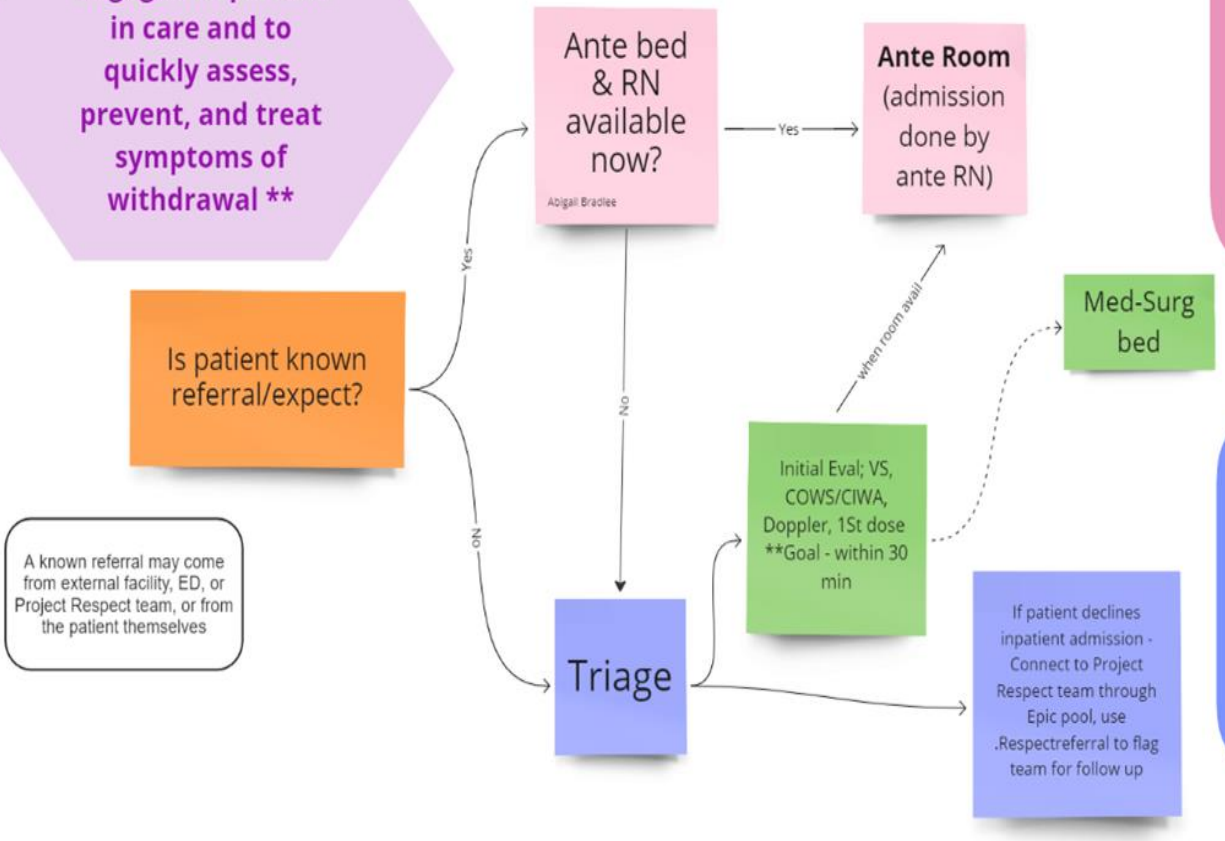
Times for provider to see patient are approximate.
Page attending 15 minutes prior to "Provider Time" if not yet evaluated by a resident.
Consider calling in back-up if unable to see patients within recommended timeframes.

*OB team, Anesthesia, Charge RN
** Chief resident and intern

Note: An Acuity Level can be increased or decreased upon completion of a full assessment of the patient as well as with collaboration with the team

Admission Process - RESPECT - MOUD Titration

**** The goal is to engage the patient in care and to quickly assess, prevent, and treat symptoms of withdrawal ****



A known referral may come from external facility, ED, or Project Respect team, or from the patient themselves

Ante RN admission tasks

- Epic admission/intake
- Vital signs
- COWS/CIWA score
- EKG ***methadone only; does NOT need to be prior to dosing, goal within 24-48 hrs admission**
- Collect utox with patient consent
- Page MFM (#4242) team or Chief (#5050) for orders/eval
- Orient pt to unit - provide pt care agreement form for review of hospital policies & MOUD titration algorithm (no signature required)
- Doppler/NST (GA & situation dependent) *can be deferred

Triage RN tasks

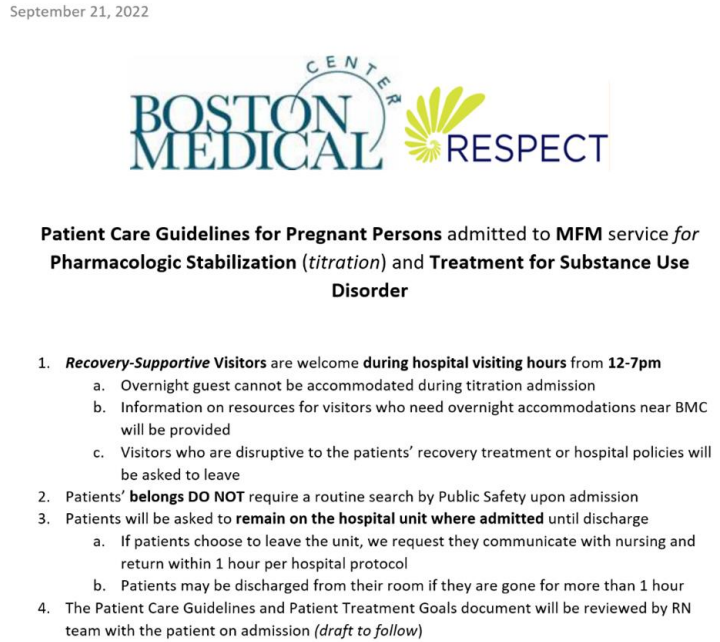
- Intake, Vitals
- Brief Substance Use history (last 1-2 weeks)
- COWS/CIWA score
- Collect utox if patient consent
- Doppler (if plan to admit to med-surg consider NST in triage if patient accepts)
- Administer 1st dose as ordered

Collaborative Treatment Agreement

Discontinued use of “contract”

Patient contracts are not evidence based, inconsistently followed/enforced, and created an uneven power dynamic right from the start of admission

Currently use a collaborative treatment agreement for inpatient expectations



September 21, 2022

BOSTON MEDICAL CENTER RESPECT

Patient Care Guidelines for Pregnant Persons admitted to **MFM** service *for* **Pharmacologic Stabilization** (*titration*) and **Treatment for Substance Use Disorder**

1. ***Recovery-Supportive* Visitors** are welcome **during hospital visiting hours** from **12-7pm**
   a. Overnight guest cannot be accommodated during titration admission
   b. Information on resources for visitors who need overnight accommodations near BMC will be provided
   c. Visitors who are disruptive to the patients’ recovery treatment or hospital policies will be asked to leave
2. Patients’ **belongs DO NOT** require a routine search by Public Safety upon admission
3. Patients will be asked to **remain on the hospital unit where admitted** until discharge
   a. If patients choose to leave the unit, we request they communicate with nursing and return within 1 hour per hospital protocol
   b. Patients may be discharged from their room if they are gone for more than 1 hour
4. The Patient Care Guidelines and Patient Treatment Goals document will be reviewed by RN team with the patient on admission *(draft to follow)*

Connection & Community

Visitors allowed in accordance with hospital wide visitor policy

Ask that visitors are recovery supportive

Engage visitors who also need recovery support to connect with other resources in hospital and surrounding area for their recovery

Case: Patient who OD'd in bathroom - staff alerted by partner, never use alone!

Project TRUST
BOSTON, MA

Belongings

Discontinued routine admission search

Conversation at admission with emphasis on patient goals and collaborative safety

Can use locked cabinet in room for belongings to protect staff and patient, but also protect privacy of belongings

Nicotine and fresh air

BMC Elopement policy allows for 1 hour off floor to hold bed (all inpatients)

Patient is asked to tell nurse/staff when they are leaving unit, and when they return.

Within 1 hour, no action taken

After 1 hour patient is contacted, if no return patient discharged but can be re-admitted through ED/OB triage

MOUD is not withheld unless clinically indicated (somnolence, low O2, RR < 8, etc)

Vapes - unofficial but can be helpful alternative

Activities & Support

Ipads - music, facebook messenger

Peer recovery coach check ins & support

Connection with outpatient team while inpatient - streamline after care

Patient Advocacy, therapy dogs

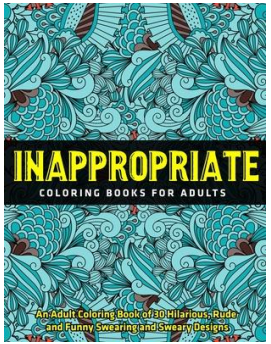
Large iced regular and a walk to Dunkin does wonders!

SUD Cart

Coloring books, makeup, nail polish, books, recovery and pregnancy information

It’s boring in the hospital!!

Pilot Program - Harm Reduction Supplies



Planning for PDD and readmission cycle

“If you need to leave now, will you please come back? I am here until 7pm, I would love to see you before I leave. I want you to be safe.”

Offer connection to harm reduction resources “do you have a way to access clean works right now? Do you know about AHOPE across the street? Do you have narcan with you?”

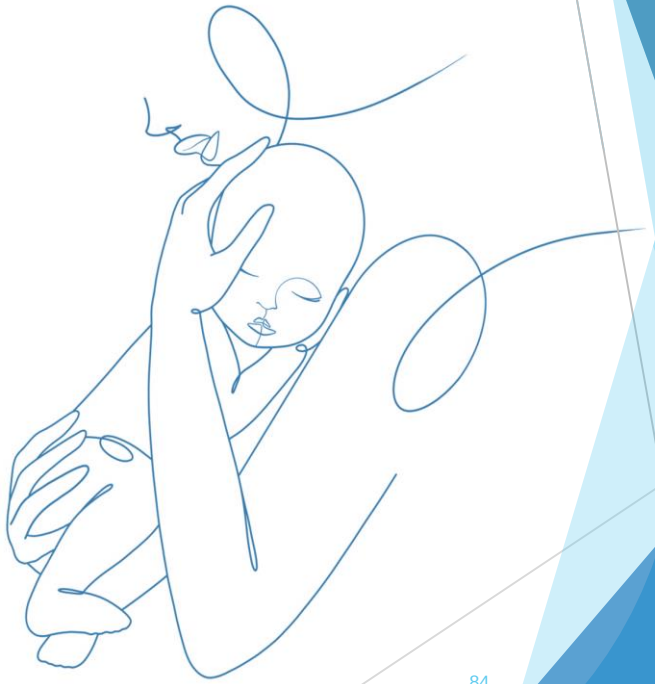
Most important - when they return - “I’m so happy to see you! I am glad you are back, I want you to be here where you are safe and we can take care of you”

Be a Champion!!!

Just a few people, whether a nurse, social worker, peer recovery coach, doctor, or any discipline, but a few people working together to stick up for the underdog, show compassion and empathy, can change the culture of a unit/hospital/program with consistent modeling of welcoming, compassionate care and harm reduction based solutions

Postpartum – *What helps?*

- **Clear & consistent communication!**
  - Validate concerns
  - Discuss ALL treatment options
  - Discuss CPS implications
  - Set realistic expectations
  - Care continuity
    - Postpartum APP hospitalists
- **Pain management planning**
- **Doulas, CRS, social work support**



HEALTH FEDERATION
OF PHILADELPHIA

Questions/Answers and Discussion

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