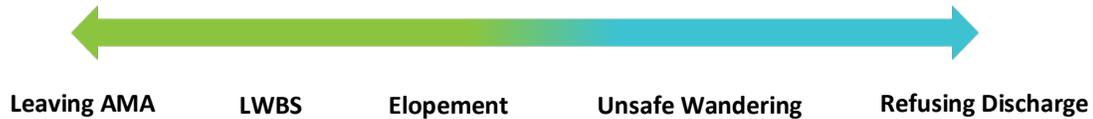


AMA and Elopement

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Introduction

This document addresses leaving against medical advice (“AMA”) and related departures from care.



This document will apply to hospital care, emergency department care, care in the office practice setting and care in the outpatient setting.

The literature is consistent with identifying AMA discharges as representing 2% of all hospital discharges. Patients who are discharged AMA are an at-risk group for both morbidity and mortality. Patients who leave AMA are much more likely to die or to be readmitted within 30 days.

Definitions

Leaving against medical advice (“AMA”) is defined as the patient’s decision to leave the facility after having been informed of and having the ability to appreciate the risk of leaving without completing treatment. Fully competent patients are legally able to discharge themselves without completing treatment. The AMA should be treated as a discharge process.

Left without being seen (“LWBS”) refers to patients leaving the ED prior to examination by a provider (Physician, APN, PA). LWBS has two meanings in the ED:

- The patient is received in the ED, triaged and a protocol has been initiated but the physician has not seen the patient and then the patient leaves
- The patient leaves the ED without being triaged

The Joint Commission and CMS believe that LWBS should be a quality indicator for hospitals as a way to monitor and manage ED overcrowding.

According to the Centers for Disease Control and Prevention (CDC), Medicaid enrollees visit EDs about twice as often as uninsured people and Medicare beneficiaries. Uninsured people and Medicare beneficiaries visit about twice as often as the privately insured.

Patients most commonly at high risk of LWBS are young males on Medicaid with low acuity illness who end up in the EDs of teaching institutions.

Elopement is defined as an unauthorized departure of a patient from an around-the-clock care setting. Elopement can be a sentinel event as defined by the Joint Commission when the elopement results in temporally related death such as suicide, accidental death or homicide or results in a major permanent loss of function. The National Quality Forum defines death or serious harm associated with elopement for more than four hours as one of its patient protection events.

Unsafe wandering occurs when the patient wanders in unsafe environments. It is important to note that the Alzheimer Association advises that wandering may represent a behavioral expression of a basic human need and wandering may have health benefits and a healthcare provider may want to consider supporting safe wandering rather than trying to stop wandering.

Elopement and unsafe wandering can result in regulatory sanctions. According to ECRI, closed claims based on elopement allegations are associated with high payouts.

Refusing discharge is becoming more common and can occur for a variety of reasons.

Managing risks and mitigating damages

Preventing the AMA: Hearing the patient and identifying the signals

The literature is consistent with concluding that patients will signal that they are thinking about leaving AMA before they actually leave AMA. Understanding this requires the providers to “hear” the patient and to have effective communication between all providers. Effective interpersonal communication includes interpreting verbal and nonverbal language. Lessard has a comprehensive resource entitled “*Effective Interpersonal Communication with Patients*”. Email Lessard at dmlessard1803@gmail.com for information.

There are two categories of recommendations related to prevent the AMA: The patient perspective and The provider and staff perspective.

From the patient perspective:

Understanding patient rationale for leaving AMA will provide opportunities to proactively address the issues.

- Cost is often an issue for older patients
- Patients who understand and fear or are apprehensive about the general risks inherent with hospitalization. These risks include exposure to infections, higher probability of falls
- Patients who believe that their providers are over-worked, stressed or burned-out and associate this perception with poor patient care
- Patients with family issues or patients experiencing emergencies at home
- Patients who express dissatisfaction with treatment

Recommendations:

- Ask patients what they need to support their hospital stay
- Provide social resources to patients
- Contact the individual responsible for processing grievances and request their presence

From the provider and staff perspective:

- Understand the statistics that result from large-scale retrospective studies that have analyzed AMA discharges:
 - Patients who left AMA were more likely to be male, have a low income, have Medicaid or be uninsured
 - Patients who left AMA cite communication as lacking in four areas: length of stay, wait time, meals and pain management
 - Contributing factors include: work flow issues where staff feel rushed, cultural issues where staff feel like the organization prioritizes patient throughput over personal connection
 - Lack of primary care physician
 - Admission through the ED
 - Admission with substance abuse related diagnosis
 - Previous AMA discharges
 - Patients citing family problems or emergencies that mandate the AMA discharge
- Understand available social resources designed to assist patients with socio-economic issues
- Know your hospital quality data and the data on the CMS hospital compare website. Provide patients with this information as it pertains to hospital acquired infections and falls

Recommendations:

- Develop programs that promote health habits among employees
- Disseminate statistics from studies

The AMA policies & procedures and documenting the AMA

The AMA policy should clearly outline the patient's right to autonomy and self-determination with the health care provider's responsibility to do what they believe is in the best interest of the patient and to limit bad outcomes (acting with beneficence and doing no harm). This would include prescribing medication, scheduling outpatient appointments and discussing with the patient's other providers.

The AMA should be treated as a discharge process and as such, should include discharge instructions and offering medication that will benefit the patient without masking worsening symptoms or complications.

The AMA policy and the medical record documentation should include all provider efforts to prevent the patient from leaving AMA, which may include as appropriate:

- Offer more pain medication
- Offer alternative diagnostic options (performing an ultrasound instead of a CT)
- Discussing patient and provider concerns with family

Communication with the patient is the top priority. A significant volume of professional and lay literature posits that 90% of health is determined by social issues, economics and lifestyle leaving 10% of health determined by medical intervention. While, this may not be true for each individual patient,

discussing social and economic issues that create barriers and providing resources may facilitate continued inpatient stay. Discussion of lifestyle in terms of contribution to health issues and as a self-care strategy and providing appropriate resources or referrals is recommended in all AMA discharges.

The AMA policy should include procedures for staff to follow if the patient is incompetent or if the patient is at risk for harming themselves or others. The guidelines and procedures should be clear while allowing for case-by-case flexibility.

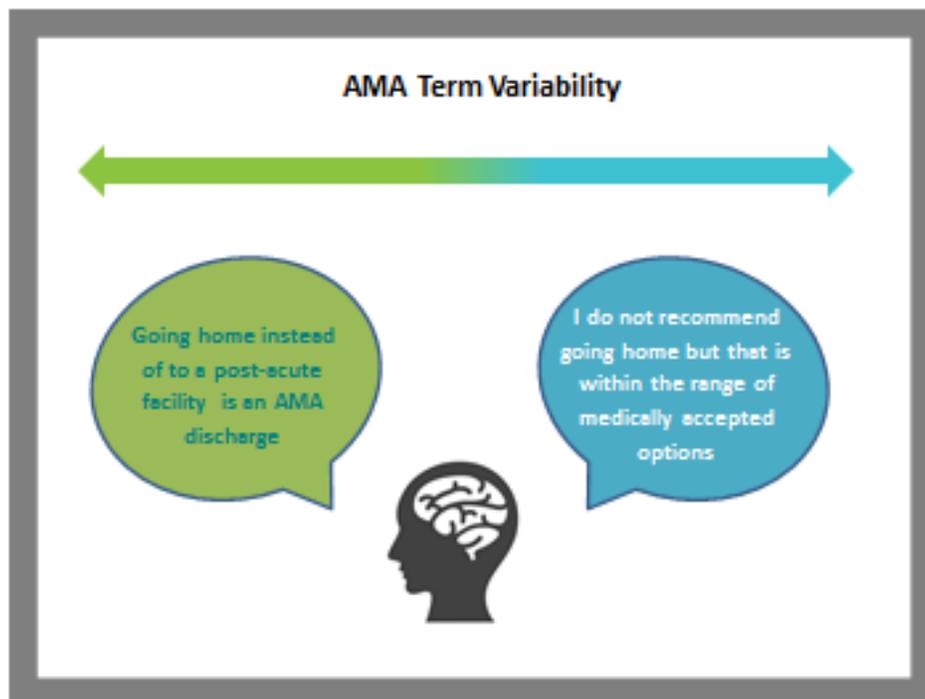
Recommendations:

- Do not blame, talk down to or berate a patient who wants to leave AMA
- Do not reduce the communication or the care to a patient expressing the desire to leave AMA
- Do not coerce the patient with threats of refusing future treatment or threats that their hospital bills will not be paid
- Provide the patient with everything that would be provided on a discharge, including prescriptions, follow up appointments and discharge instructions
- If the patient is at risk for harming themselves or others, an evaluation for involuntary commitment should be performed.
- If the elements for involuntary commitment are not met, there should be an objective method of determining risk that correlates with the ability to initiate a legal/medical hold for being a danger to themselves and includes the ability to physically or chemically restrain or to call for assistance from local law enforcement.
- Documentation should clearly provide the risk and assessment that resulted in letting the patient leave the hospital AMA, the restraint or the call to law enforcement
- AMA documentation should mirror the informed declination form and include:
 - The patient has decided to leave AMA because they state:
 - The patient has been assessed to have the capacity to make decisions by the following:
 - An example of what would be appropriate to include in this section of documentation: “The patient is clinically sober, free from distracting injury, appears to have intact insight, judgment and reason and in my opinion has the capacity to make decisions.”
 - The patient and the provider agree on the following symptoms and the patient understands the provider’s assessment, diagnoses and concerns.
 - The risks have been explained to the patient:
 - The benefits of remaining in the environment /admitting to the hospital have been explained:
 - Alternatives to leaving AMA have been explored and explained:
 - The patient understood risks and benefits and did so by _____. The patient had an opportunity to ask questions about their medical condition and the significance or consequences of leaving AMA. This was witnessed by _____ and author of documentation
 - The patient was provided: prescriptions, follow up appointments, discharge instructions

Inpatients who decide to go home rather than to a recommended post-acute care facility

This situation presents ethical issues for the provider and financial issues for the patient. A core issue is to determine or define whether going home is considered AMA when the provider is recommending admission to a post-acute care facility.

There is individual provider variability with the use of the term “AMA”.



If the home-bound patient is readmitted within 30 days of discharge, Medicare will penalize the hospital unless the original discharge was documented as AMA.

Recommendations:

- Define AMA within your organization
- Informed refusal/declination is a process and not a signature on an AMA form. This process includes an evaluation and documentation of capacity addressing the patient goals and values along with the treatment alternatives and consequences (risks of refusing/declining treatment).
- Include family and social resources when addressing post-care planning
 - A social resource that is underutilized is the “Medical Legal Partnership”. These partnerships analyze individual situations where an individual’s medical, health or well-

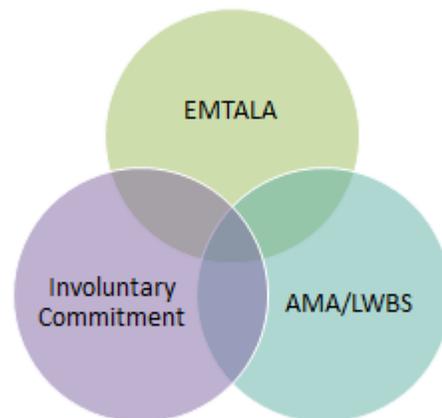
being is affected by an issue having legal ramifications. The Partnership then provides the legal assistance that is needed to overcome or remedy the issue, thus removing the legal barrier or obstacle contributing to a medical outcome. The National Center for Medical Legal Partnership website contains information on the services that these Partnerships provide. See <https://medical-legalpartnership.org/>

- Research indicates that 60% of a person's health is determined by social factors.

AMA or LWBS in ED and Urgent Care

Patients in the ED and Urgent Care Centers who are under a hospital license and meet the Dedicated Emergency Department (DED) criteria and who leave AMA or LWBS present multiple challenges related to EMTALA requirements and state involuntary commitment requirements.

Additionally, patients with mental health disorders or substance abuse disorders are at a significantly higher risk for leaving AMA or LWBS. It is estimated that one out of every eight emergency department visits is for mental health or substance abuse disorders. In general, state inpatient psychiatric hospital beds do not meet patient demand causing individuals to turn to the ED as a way to obtain behavioral health care.



EMTALA

EMTALA requires dedicated emergency departments to provide medical screening under 42 CFR 489.24. A dedicated emergency department (DED) meets the requirements of a medical screening if it:

- offers the patient the further medical examination and treatment required under Section 1395dd(a);
- informs the patient or another on his behalf "of the risks and benefits of the offered examination and treatment";

- and the patient or another acting on his behalf refuses to consent to the examination and treatment.

The regulations also provide that:

- the medical record must contain a description of the examination and/or treatment which was refused;
- the hospital must take all reasonable steps to secure the refusal in writing;
- the document to be signed by the patient should include a recitation of the fact that the patient or other acting on his behalf has been informed "of the risks and benefits of examination or treatment". 42 CFR 489.24(d)(3)

EMTALA applies to a dedicated emergency department (DED). The CMS regulation defines "dedicated emergency department" as any department or facility of the hospital that either:

- (1) is licensed by the state as an emergency department;
- (2) held out to the public as providing treatment for emergency medical conditions; or
- (3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis

The urgent care center owned or operated by a hospital that provides emergency treatment in one-third of its cases may constitute a "dedicated emergency department." The Medicare State Operations Manual underscores this analysis by specifically stating that "[h]ospitals that may meet this one-third criterion may be specialty hospitals (such as psychiatric hospitals), hospitals without 'traditional' emergency departments, and urgent care centers. In addition, it is not relevant if the entity that meets the definition of a dedicated ED is not located on the campus of the main hospital."

If an urgent care center is attached to a hospital and is not under a hospital license, it could be asserted that the urgent care center is held out to the public as providing treatment for emergency medical conditions. In this situation, the following questions should be considered:

- Does the hospital also have a DED?
- If so, how is the urgent care center distinguished from the DED

There should be adequate and appropriate signage that provides definitive information and responses to these questions.

Recommendations

- Follow the general AMA recommendations
- Prepare for an EMTALA investigation should a complaint be alleged by a patient who left AMA or LWBS. If an EMTALA complaint is alleged, the investigator will begin with an entrance conference with CEO/president (or designee) and any other appropriate staff. The following documentation will be necessary. A review of these policies/procedures and QA of documents and processes (for completeness, appropriateness) are recommended as a proactive risk management measure to ensure that in the event of an EMTALA investigation, all documentation will be available.

- Dedicated ED logs for the past 6-12 months
- The dedicated ED policy/procedures manual (review triage and assessment of patients presenting to the ED with emergency medical conditions, assessment of labor, transfers of individuals with emergency medical conditions, etc.)
- Consent forms for transfers of unstable individuals
- Dedicated ED committee meeting minutes for the past 12 months
- Dedicated ED staffing schedule (physicians for the past 3 months and nurses for the last 4 weeks) or as appropriate
- Bylaws/rules and regulations of the medical staff
- Minutes from medical staff meetings for the past 6-12 months
- Current medical staff roster
- Physician on-call lists for the past 6 months
- Credential files including the director of the emergency department and emergency department physicians. Review of credentials files is optional. However, if there has been a turnover in significant personnel (e.g., the ED director) or an unusual turnover of ED physicians, or a problem is identified during record review of a particular physician's screening or treatment in the ER, credentials files should be obtained and reviewed
- Quality Assessment and Performance Improvement (QAPI) Plan (formally known as Quality Assurance)
- QAPI minutes (request the portion of the quality improvement minutes and plan, which specifically relates to EMTALA regulations. If a problem is identified that would require a more thorough review, additional portions of the quality improvement plan and minutes may be requested for review)
- List of contracted services (request this list if a potential violation of §1866 and 1867 of the Act is noted during the investigation and the use of contracted services is questioned)
- Dedicated ED personnel records (optional)
- In-service training program records, schedules, reports, etc. (The EMTALA investigator may request an optional review if questions arise through interview and record review regarding the staff's knowledge of 42 CFR §489.24)
- Ambulance trip reports and memoranda of transfer, if available (to be selected by you if the cases you are reviewing concern transfers)
- Ambulance ownership information and applicable State/regional/community EMS protocols.

Involuntary Commitment

For mental health patients, EMTALA's MSE typically has two steps:

- (1) an initial exam to rule out organic causes of mental disorder
- (2) a psychiatric review.

Additionally, hospitals must also assess to determine that a medical EMC does not exist. This makes it important that physicians don't ignore the screening for a medical EMC and just perform one that addresses mental health. If an MSE is performed and does not reveal an EMC, the hospital has no

further obligation under EMTALA. Likewise, a hospital's EMTALA obligation ends if the physician stabilizes the patient and all EMCs identified are addressed, the hospital admits the patient in good faith, or provides all treatment within their capabilities and makes an appropriate transfer.

Recommendations

- Know your state involuntary commitment laws and regulations
- Know your state duty to warn laws and regulations
- Anticipate that patients may want to leave AMA or LWBS if the dedicated crisis responder is unable to timely arrive to ED to assess and initiate transfer,
- Document time of
 - Patient arrival
 - Assessment
 - Referral call to DCR
 - DCR response
 - Action taken if untimely response
 - Reasoning and decision-making process for action
- Document actions taken to stabilize patient
- Document assessment of when stabilization has been met.
- Document all conversations related to “*imminent likelihood of serious harm*” and “*imminent danger because of grave disability*” with patient, persons accompanying patient and DCR
 - Patient or others may provide inconsistent statements to ED staff and DCR

Leaving AMA when intoxicated

The patient does not have the capacity to provide informed refusal when intoxicated. Diagnosis of intoxication is determined by the legal limit of intoxication in the jurisdiction and not by observation.

Capacity refers to an assessment of the individual's psychological abilities to form rational decisions, specifically the individual's ability to understand, appreciate, and manipulate information and form rational decisions. If the physician evaluates a patient and determines that the patient lacks capacity, then the patient is referred to as *de facto incompetent*, i.e., incompetent in fact, but not determined to be so by legal procedures.

Competency is a legal term and is determined by a court. Competency is a broad concept encompassing many legally recognized activities, such as the ability to enter into a contract, to prepare a will, to stand trial, and to make medical decision. The definition, therefore, must be clarified depending on the issue in question. Competency refers to the mental ability and cognitive capabilities required to execute a legally recognized act rationally.

The ethics literature further defines capacity related to decisions as “decisional capacity” and characterizes this as dynamic. An individual can have decisional capacity on one day and not on another day. These dynamic situations occur when there are reversible causes of impaired decisional capacity

which includes intoxication, hypoxia, stress or sedation. The literature also suggests that capacity level is decision specific.

The patient does not have the capacity to provide informed consent or informed refusal/declination when intoxicated. As stated above, diagnosis of intoxication is determined by the legal limit of intoxication (known as legal intoxication) in the jurisdiction and not by observation.

However, alcohol tolerance is individualized. A person who has a long history of using alcohol may have a high tolerance level and not be clinically intoxicated at the same time that they are legally intoxicated. This should be documented, but because the patient is legally intoxicated, the patient does not have capacity.

If the patient's blood alcohol level is under the legal limit but appears clinically intoxicated, this too, should be documented and considered when making a capacity assessment. It is possible to not be legally intoxicated and not have decisional capacity.

The universal question related to leaving AMA when intoxicated, but not at the legal limit of intoxication is, whether a patient who has been assessed to not have decisional capacity can be held against their will.

Many times, this category of patient (known as clinically but not legally intoxicated) will not meet the involuntary commitment requirements. In these cases, there may be a different route to provide a temporary legal/medical hold for a patient who may be a danger to themselves or others or who may not appreciate the risks of leaving AMA.

There may be legal ramifications and consequences for ordering or not ordering a blood alcohol level on a patient. The treatment or observation plan should be clearly articulated in the hospital policy and procedures.

Recommendations:

- Talking with the patient and asking if they would be willing to remain hospitalized until they are clinically sober
- Recognize that there is poor correlation between degree of intoxication and the patient's clinical presentation
- Document the psychomotor and cognitive impairments
- Document the blood alcohol level
- Determine whether the patient will need to be observed until they are below the legal blood alcohol limit and/or are clinically sober

Leaving AMA with IV or PICC line

Leaving AMA with an IV or PICC line that was ordered be discontinued before discharge is a challenging issue. This issue is frequently encountered and providers respond in a variety of ways from restraining the patient to remove the IV/line to calling local law enforcement. Restraining the patient to remove the IV/line as well as visiting their home to remove the line seems to be a common response but is

fraught with legal consequences. The patient could assert a civil assault/battery claim or file a criminal complaint. If the IV/line is not removed and the patient uses this for non-prescribed or illegal drug access, the patient may suffer severe or fatal consequences.

The provider has a legal duty, a professional responsibility and an ethical obligation to respect patient autonomy, provide a safe environment, do good (beneficence) and do no harm (non-maleficence). Navigating duty, responsibility and obligations requires balancing of risks and benefits from both the patient and provider perspectives.

“Harm Reduction” is a controversial proactivity that is used with patients having known substance abuse.

Recommendations

- Prevention: Accept that patients who have substance abuse problems will continue to look for ways to use drugs during and after hospitalization. Patients who are admitted to a hospital for a non-substance abuse diagnosis are likely not interested in having their addiction treated. Therefore, “harm reduction” should be considered as part of the treatment plan and should include educating providers on how to avoid withdrawal or prevent the patient from illicit drug overdosing. Guidelines should be developed that address how to care for the addiction patient without requiring detoxification treatment. Forced detoxification when treating comorbidities often leads to leaving AMA with the IV/PICC line. Harm reduction strategies include:
 - Honest and judgement-free conversation about the type of drug and dosage with the intent to prevent or treat the withdrawal during the course of the hospitalization.
 - Education may be necessary to define this as “not enabling addiction” or “helping the patient get high”, but is devised to keep the patient comfortable.
 - Patient-provided drug information will enable assessment of possible drug interactions
 - Frank discussions with hospital executives, legal and risk management as to the risks and benefits of providing patients with clean injecting supplies.
 - Recognition that prescribed and timed opioid administration to an addict may not be adequate.
 - For addicts who inject, the process of injecting is part of the addiction. While injecting illicit drugs should be discouraged along with offering alternatives and counseling patients on the risk of taking street drugs while hospitalized, the hospital should also consider the controversial value of providing clean injecting supplies should be discussed.
 - Education with opportunities to surface individual bias related to treating addicts should be provided. This education can include communication with patients to lessen or prevent stigmatizing the patient
- A policy should be developed with legal input
- Ideally, the policy should be developed with the input, knowledge and agreement of local law enforcement

- Always inform Risk Management when this situation occurs
- Provider actions should be clear to the patient and documented thoroughly. The patient should be advised that the hospital cannot support their leaving AMA with an IV or PICC line and ask the patient to return to have it removed. If the patient does not willingly comply, the patient should be advised of the next step which likely involves notifying local law enforcement.
 - Notifying law enforcement and HIPAA: The *HIPAA* Privacy Rule permits a covered entity to disclose PHI, including psychotherapy notes, when the covered entity has a good faith belief that the disclosure: (1) is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others and (2) is to a person(s) reasonably able to prevent or lessen the threat. This may include, depending on the circumstances, disclosure to law enforcement, family members.
 - If notifying law enforcement, all steps taken before the notification should be documented in the medical record. The rationale underlying the decision to notify law enforcement should be documented.

Elopement/Unsafe wandering

Elopement or unsafe wandering can occur in any setting. After an individual, patient or resident is reported missing, a missing person protocol should be immediately enacted.

Incidents that involve elopement and unsafe wandering can result in regulatory sanctions, civil litigation and/or criminal action. In ECRI's Healthcare Risk Quality and Safety Guidance, published 2/1/19, they report that closed claims based on elopement allegations are associated with high payouts.

Elopement is a sentinel event as defined by the Joint Commission: Sentinel events result in death, permanent harm, or temporary harm.

Recommendations:

Engage in annual self-assessments to assess monitoring and care provided to people with dementia.

Develop a missing person protocol. A missing person protocol includes:

- Search: Immediate search of internal and external areas. Search grids are recommended as they can facilitate a deliberate and coordinated effort.
- Notification: If the individual is not found within a defined period of time, notifications begin. Although there is no collective agreement on what constitutes an appropriate defined period of time, most of the literature identifies 30 minutes as the time to search before notification begins.
 - Notification protocol include family, physician, law enforcement, risk management/legal counsel, media
 - Statements should be pre-planned for media involvement.
 - The Alzheimer's Foundation of America recommends using the Silver Alert program which was modeled after the Amber Alert system. The goal of the

Silver Alert system is the quick dissemination of information to law enforcement personnel and to the general public. The system disseminates information via robo calls, digital billboard signs, television, texts, and emails.

- Notification may be performed by different staff and the protocol should include which staff role notifies which party
- Notification and HIPAA: HIPAA outlines the conditions under which the disclosure of sensitive health information is legally permissible. Under HIPAA, disclosure of protected health information is permitted without an individual's authorization in particular situations. Disclosure of this information to law enforcement agencies is permitted for the purposes of identifying or locating a suspect, fugitive, material witness, or missing person.
 - Notifying law enforcement of a missing patient does not constitute a HIPAA violation
 - There may be ramifications when disseminating this information to the general public. A central aspect of the Privacy Rule is the principle of minimum necessary use and disclosure, which instructs that reasonable efforts must be made to use, disclose, and request only the minimum amount of protected health information necessary to accomplish the intended task. This highlights the rationale underlying the need for comprehensive medical record entries.
 - HIPAA does not provide guidance when there is a difference between states with the Silver Alert criteria. For example, if a patient elopes from state A and might be found in State B, issues arise as to which state would be responsible for activating a Silver Alert and what to do if the patient meets the criteria in state A but not state B. As in all HIPAA related decisions, a balancing of outcomes will be required and the thought process should be documented in their medical record.
- Injury treatment: Assume the individual will be injured and have a general treatment plan in place
- Event mitigation: documentation of every action
 - If media is involved, emphasize the goal of safety and willingness to provide information immediately after confirmation of patient/resident safety
 - The narrative should focus on an unfortunate event that was well managed rather than focusing on the error
- Debrief and focus on how to avoid a future event

Periodic elopement drills should be conducted. Performance should be analyzed to identify weaknesses. For example, in 2010, an elopement study was conducted at the Los Angeles Veterans Administration facility and they concluded that the first major flaw in their attempt to locate a missing patient was their lack of using search grids.

Dementia patients in ED

Dementia patients in ED are at risk for elopement and unsafe wandering.

Recommendations:

- Wrist bands that identify patients at risk for elopement and unsafe wandering
- Train volunteers to sit with or observe this at-risk patient population
- Document the at-risk patient and the prevention plan upon recognition that the patient is at-risk

Leaving without being seen (LWBS)

The Joint Commission and CMS believe that LWBS should be a quality indicator for hospitals as a way to monitor and manage ED overcrowding.

According to the Centers for Disease Control and Prevention (CDC), Medicaid enrollees visit EDs about twice as often as uninsured people and Medicare beneficiaries. Uninsured people and Medicare beneficiaries visit about twice as often as the privately insured.

Patients most commonly at high risk of LWBS are young males on Medicaid with low acuity illness who end up in the EDs of teaching institutions.

LWBS results in: reimbursement consequences, reputation damage and medical professional liability.

Recommendations:

- LWBS is a symptom and a result of non-ideal ED care. Ideal ED care results from three variables: flow, safety and reliability. These three variables should be analyzed.
 - *Patient flow* is the management and coordination of progressive movement throughout the ED and hospital system.
 - A significant factor in LWBS is ED overcrowding. A significant factor in ED overcrowding is the inability to move admitted patients out of the ED to an inpatient unit.
 - Much research has been performed regarding patient demographics, time of day and location of ED. The results of the ED analysis and the research will yield actionable insights
 - *Safe care* is achieved when patients are not harmed. Root causes of harm include errors during interventions or delays in performing interventions
 - *Reliability* is a measure of failure-free operation as over time. Healthcare is reliable when interventions are evidence-based and are provided timely

AMA / and Informed Refusal/Declination process and forms

Process

I have reviewed hundreds of AMA and Informed Refusal forms and concluded that the majority of these forms are developed from a paternalistic perspective, which by definition, is the opposite of patient-

centered care, does not respect patient autonomy and undermines shared decision making. The majority of these forms also do not include defining the range of medically accepted options.

As with informed consent, the emphasis is on the process, not the form. The provider should analyze their reasons for wanting a patient to remain hospitalized and seek to understand their patient's reasons for leaving.

If the patient wants to discharge themselves from an outpatient setting or from a provider's practice or if the patient refuses or disagrees with the provider's treatment recommendations, the provider should seek to understand their patient's reasons.

The provider should also understand that they may be entrenched in a position where they are not examining their own personal reasons for insisting on a particular treatment regime.

The provider's reasons may be hidden in their personal or cultural biases known as cognitive or implicit bias. The provider may be explicitly reacting because of their belief that they are being personally challenged. In reacting, the provider can become defensive and react paternalistically.

The patient may have valid, sound and legitimate reasons for not wanting to remain hospitalized because hospitalization can pose significant risks. These can include:

- Family suggestions/influence
- Increasing risk for infection and falls
 - For a geriatric or immune-compromised patient could lead to long term care or skilled nursing care
- Increasing the number of days in bed can reduce mobility and trigger confusion, agitation and delirium

The provider should understand that the provider and patient likely operate and communicate from two distinctly different frameworks. The provider traditionally operates from a disease framework and focuses on the patient history, treatment plan and care management. The patient is likely operating from an illness framework which includes expectations, fears, anxieties, and perceptions about the healthcare system, health insurance and their illness.

The AMA/Informed Refusal process should include identifying creative, doable options for the patient and from the patient perspective that provide the elements of patient safety and sound medical treatment. This could include remaining hospitalized and permitting pet visits, arranging outpatient or home visits or addressing social or legal root causes of not wanting to remain hospitalized.

Forms

If the patient is leaving AMA, it is best practice for the patient and the provider to sign the AMA form. If the patient declines to sign the form, the declination should be documented on the form and signed by the provider and a witness. The declination should be documented in the medical record.

An AMA form is different from an informed refusal/declination form. The informed refusal/declination may be used when the provider advises a specific treatment regime or course of action and the patient refuses or declines to adhere. Informed refusals/declinations may or may not represent “against medical advice.” The refusal or declination may be within the range of medically accepted options when the provider is presenting and discussing options, but it is not the provider’s recommended option.

Refusing discharge

Not wanting to leave the hospital is not always the same as refusing discharge. Patients may be reluctant to leave and refuse discharge for a variety of reasons including:

- Not understanding their diagnosis
- Not understanding discharge instructions
- Fear and anxiety about recovering at home
- Family issues at home
- Feeling like they may be a burden to the family
- Safety issues at home
- Malingering

Family members may also express reluctance for the discharge and may challenge the provider’s decision to discharge.

The refusal for discharge presents unique challenges and will require the provider to understand and analyze the root cause for the reluctance to leave. Questions regarding sensitive topics like domestic abuse, fear of falling at home, homelessness, etc will likely be required.

The provider may expect the patient or the family members to be aggressive or hostile. Keep in mind that this behavior does not mean that the patient lacks sound reasoning for not wanting to leave the hospital.

Recommendations:

- Develop a discharge policy that informs the patient of discharge 24-48 hours in advance of discharge. Check to see if your state has any law or regulations that address notice of discharge. This policy should be placed in patient-facing documents that are received upon admission
- Develop a discharge appeal process. This policy should be placed in patient-facing documents that are received upon admission
- Discuss creative, doable options that address the patient’s reasons for not wanting to be discharged and provide the relief or solutions that the patient is seeking

- Come to the conversation prepared with resources
- DO NOT coerce a discharge by threatening financial consequences. This requires a distinction between coercion and providing information
- Discuss the situation with risk management
- Be wary and minimize the influence of peers and staff who suggest or try to persuade immediate discharge. You, as the provider, have to believe and provide support for the appropriateness of the discharge. Your medical decision making should be clearly documented
- Have a security protocol in place to address aggressive behavior. If elevation to local authority will result in an arrest, assure that all documentation is thorough, comprehensive and complete including evaluation of different diagnoses and the testing to support the elimination of a diagnosis. Any abnormalities should be explainable and explained in the record

Billing

AMA

The literature suggests that many providers believe that patients who are discharged AMA are held financially responsible for their bills and providers have counseled patients accordingly. The literature also contains studies revealing that providers threaten financial consequences to patients who want to leave AMA as a coercive strategy to keep the patient in the hospital. Many AMA forms contain language such as "I agree to be responsible for any part of the bill that is not covered by insurance because I left the hospital".

It is not ethical to scare patients with misleading information. PI recommends that accurate billing information be attained and confirmed with the payer.

The discussion and the time spent discussing AMA and informed declination should be documented.

LWBS

CMS FAQ 2297 states that hospitals cannot bill Medicare for the lowest level ER visit for patients who check into the ER and are 'triaged' through a limited evaluation by a nurse but leave the ER before seeing a physician....The limited service provided to such patients is not within a Medicare benefit category because it is not provided incident to a physician's service.

Hospital outpatient therapeutic services and supplies (including visits) must be furnished incident to a physician's service and under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law. Therapeutic services provided by a nurse in response to a standing order do not satisfy this requirement."

LESSARD

AMA Formⁱ

**Patient's Acknowledgment That They Are Leaving Against Medical Advice
Informed Refusal/Declination**

This signed document is my formal statement acknowledging that I _____, a patient of/ at _____ am making an informed decision to decline the recommended advice of my provider.

My provider _____ has recommended the following treatment/procedure/plan:

The risks and benefits of the recommended advice of my provider have been explained to me. We have discussed alternatives. I have had an opportunity to discuss the risks and benefits and understand the risks and benefits that were recommended by my provider.

We have discussed the potential benefits and they include:

- Additional diagnostic testing and other follow-up
- Treatment, monitoring and/or managing my condition
- Medication administered via IV or PICC line
- Other benefits:

We have discussed the potential risks up to and including death and they include:

- Death
- Permanent disability/disfigurement
- Additional pain and/or suffering
- Risks to unborn fetus
- Other risks:

We have discussed the following alternatives with their potential benefits and risks and they include:

My signature acknowledges that:

1. My medical condition has been evaluated and explained to me by my provider who has recommended the above treatment/procedure/plan. We have discussed my condition and I understand my condition.
2. My provider has explained and we have discussed and I understand the potential benefits and risk of the recommended treatment/procedure/plan and alternatives.

3. My provider has explained and we have discussed and I understand the potential risks with not following through with the recommended treatment/procedure/plan.

4. I have had an opportunity to discuss all questions related to the recommended treatment.

I am declining to consent to the recommended treatment and am voluntarily leaving against medical advice.

I am leaving:

- On my own
 - Walking
 - Driving
- Accompanied by _____
- Using a ride share
- Using public transportation

Medication and driving:

I acknowledge that I may be experiencing side effects from medication which may alter my ability to drive.

I acknowledge that I have been advised that it is unsafe for me to drive and that if I drive, the providers at _____ will contact the local authorities.

PATIENT OR REPRESENTATIVE PRINT

PATIENT OR REPRESENTATIVE SIGNATURE

REPRESENTATIVE RELATIONSHIP

DATE

The patient or representative has read this form or had it read to him or her.

The patient or representative states that he or she understands the information in this form.

The patient or representative has no further questions.

PROVIDER SIGNATURE

DATE

WITNESS PRINT

DATE

WITNESS SIGNATURE

DATE

WITNESS CONTACT INFORMATION:

ADDRESS

PHONE

LESSARD

Resources

http://www.hcca-info.org/Portals/0/PDFs/Resources/Rpt_Medicare/2013/rmc031813.pdf

https://www.cdc.gov/nchs/ppt/nchs2010/54_pines.pdf

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4033834/>

<https://www.ecri.org/components/PSOCore/Documents/E-Lert/E-lert10%20-%20When%20Patients%20Leave%20against%20Medical%20Advice.pdf>

https://www.ecri.org/components/HRC/Pages/SAQ12.aspx?_cldee=ZGVib3JhaGxAcGh5aW5zLmNvbQ%3d%3d&recipientid=contact-00bcc1b7048ce7118103005056936fe1-cd5cd4f1232746ffa85c5f2d2ab17e7c&esid=ead6fcbc-932f-e911-8126-005056936fe1

<https://psnet.ahrq.gov/webmm/case/96/Discharge-Against-Medical-Advice>

<https://healthydebate.ca/2016/07/topic/harm-reduction-hospitals-injection-opioids>

<https://www.aliem.com/2014/03/patient-sober-clinical-sobriety-versus-blood-alcohol-concentration/>

https://www.nursingcenter.com/nursingcenter_redesign/media/nursingcenter/aonfiles/leading-age-elopement-direct-care.pdf

ⁱ Many AMA forms include a waiver or release of liability. I have never been an advocate of this, as I do not think it adds additional protection for the provider. I acknowledge that others believe it incentivizes the patient to reconsider their decision and as a result, the patient may not leave AMA.

I believe this form is strong enough on its own to provide incentive to stay.

I believe a waiver introduces elements of coercion which makes the decision to rescind the decision to leave AMA, coerced instead of voluntary.