

Interrupted Inpatient Continuity in DLBCL: Homelessness, Against-Medical-Advice Discharge, and Resource-Use Patterns in a Propensity Score–Matched NIS 2016–2020 Cohort

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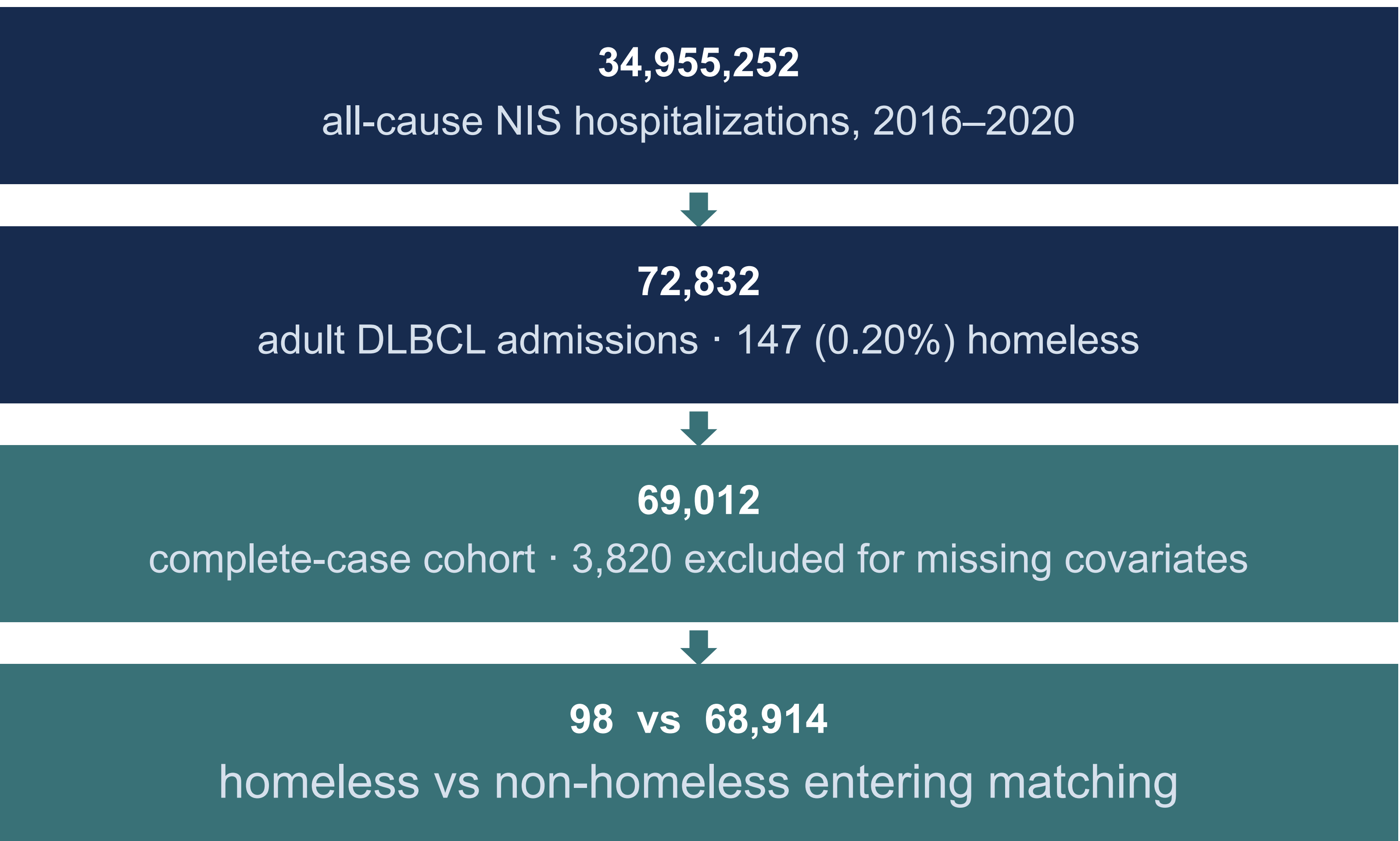
Background

DLBCL is curable only if therapy is completed without interruption. Homelessness can break that continuity, and discharge against medical advice (AMA) marks the point where an admission ends early. This association is not well characterized in DLBCL.

Methods

Design: Retrospective analysis of the NIS (2016–2020).
Homelessness: ICD-10-CM Z59.0.
Primary outcome: AMA discharge.
Secondary: complication composite, $\ln(\text{LOS} + 1)$, $\ln(\text{total charges} + 1)$. ATET by complete-case 1:3 nearest-neighbor propensity score matching (1:1 as sensitivity), adjusted for age, sex, race, payer, ZIP income quartile, weekend and elective admission, hospital bed size, teaching/location, region, Elixhauser score, and year.

Study Population



Results

Conclusion: Among propensity-matched DLBCL hospitalizations, homelessness carried 9.5 additional against-medical-advice discharges per 100 admissions (95% CI 5.1–14.0; $p < 0.001$) - about one extra AMA discharge for every ten hospitalizations. Length of stay did not differ, while complications and charges were lower; because ascertainment depends on how long a patient is observed, these should not be read as safer or more efficient care. Disposition did not explain the pattern. Findings support early inpatient social-risk response pathways, and warrant prospective multi-institutional study before guiding practice.



Discussion

Leaving against medical advice was the dominant finding. Homeless patients had 9.5 more AMA discharges per 100 matched admissions-about one extra early departure for every ten hospitalizations.

Fewer complications and lower charges do not mean better care. Complications were 11.8 points lower and charges about 21% lower, but a complication can only be documented while the patient is still hospitalized, and charges reflect care actually delivered. Patients who leave early accrue less of both.

Discharge destination does not explain the pattern. Homeless and non-homeless patients were equally likely to be discharged somewhere other than home (adjusted OR 0.98; 95% CI 0.63–1.54), and accounting for destination did not change the other results.

Intervene during the admission, not at discharge. Care breaks down while the patient is still hospitalized, so social work and housing navigation should start early in the stay.

Limitations

Only 98 exposed admissions, The NIS counts admissions, not patients; charges are not costs; residual age imbalance persisted (SMD -0.088). Stage, IPI, regimen, and post-discharge outcomes are unobserved.