When Expressing Gratitude, Don’t Focus on Yourself

Practicing gratitude — making a deliberate point of being thankful for the positive things in your life — is good for your happiness and well-being. But when we express our gratitude to others, we have a tendency to talk about ourselves when we should be thinking about them.

Often when we get help and support, we want to talk about how the favor made us feel: “It let me relax…” or “It makes me happy…” But expressing gratitude shouldn’t be all about you. Helpers want to see themselves positively and to feel understood and cared for, which is difficult for them to do if you won’t stop talking about yourself.

So the next time you thank someone, try “other-praising” instead. Acknowledge and validate your benefactor’s actions: “You go out of your way…” or “You’re really good at…” Doing so will strengthen your relationship with that person.

Harvard Business Review: Adapted from “Stop Making Gratitude All About You,” by Heidi Grant Halvorson
What is Probate Conservatorship?
- Court proceeding where judge appoints someone to manage personal and/or financial affairs of an individual lacks mental capacity to make decisions for themselves due to a medical (not psychiatric) condition
- Most often initiated through county Public Guardian’s office OR family hiring a private lawyer OR family pursuing conservatorship for free through local Superior Court
- If patient determined to be incompetent, SW begins process to find viable decision maker. If no surrogate decision maker is found, the Public Guardian’s office is contacted to present the case
- Two parts to referral packet:
  o Referral Form (SW)
  o Capacity Declaration and Attachment (MD)
- Can take up to 3-5 weeks for temporary conservatorship and longer for permanent conservatorship

What is Medical Probate?
- A court petition that allows a medical practitioner the legal right to give informed consent for medical procedures and to authorize temporary placement of an incapacitated patient at a post-acute facility
- The petition lasts up to 90-120 days from the time the patient is placed outside of UCSF
- Once the petition expires, one of the following occurs:
  o If patient is determined to have decision-making capacity, patient resumes his/her decision making rights
  o If patient remains incapacitated, the facility medical director assumes responsibility for patient’s decisions OR the facility pursues Probate Conservatorship
- MD completes Medical and Capacity Declaration form
- Take 2-3 weeks for Med Probate to be approved once forms received

What can be done for this patient?
- Full assessment of living situation: Can we bring more resources to this patient? Reach out to outpatient case management team
- Documentation in chart of lack of medical decision-making capacity and no identified next of kin
- Post-acute placement
- Consider initiating Probate Conservatorship vs. Medical Probate process

Probate Conservatorship vs. Medical Probate: What are the Differences?

**Probate Conservatorship**
- Requires approval of Public Guardian’s Office
- Takes longer to approve than Med Probate
- It is PERMANENT

**Medical Probate**
- Processed by UCSF Legal Affairs Office
- Generally quicker than Probate Conservatorship and allows patients to be placed faster
- It is TEMPORARY and thus facilities need to consider other avenues for decision-making once it expires
Decreasing LOS: Collecting and Analyzing Avoidable Days Data

Background
- UCSF remains one of the most expensive places to provide care
- One of the largest drivers of cost is LOS
- After falling in 2015, LOS on Medicine is rising again (even after adjusting for CMI)

Current State
- We have data on delays in discharge (Mourad, Patel)
- Delays during hospitalization are less well-characterized
- Case managers are marking reasons for delays during MDR, but we’re not capturing the physician’s perspective
- We collected daily surveys from physicians on reasons for delays that result in an extra day in the hospital (i.e. avoidable days)

Avoidable Days Pilot
- Physician reported avoidable days
  - Started May 2016
  - 2 months data (5/1 - 6/30)
  - 134 responses
  - 123 avoidable days captured
- Daily surveys via Murmur software (SMS link to Redcap) asking:
  1) which patients had avoidable days?
  2) why? [free text]
- Weekly review of responses to:
  - categorize the delay
  - determine if avoidable or not
Clinical Reflections Case Summary

68 yo M with COPD, HTN, OSA admitted in Feb ’16 for elective spine surgery with complex > 6 week post-op course notable for acute R segmental PE, PEA arrest, colonic perforation s/p ex-lap for R colectomy and ileostomy, septic shock, and ARDS. Transferred to medicine and switched from heparin gtt to LMWH for treatment of PE. Noted to have ostomy bleed on 3/19 and LMWH held for 48 hours for GIB. Remaining hospital course outlined below.

How did this preventable adverse event and readmission happen?

Active Errors
- R2 did not remove LMWH from d/c med list
- SNF MD did not identify discrepancy between d/c med list and d/c summary

Contributing Factors
- Med rec performed 1 week prior to d/c
- D/c day/time not anticipated
- D/c performed by R2 (w/ 5 other discharges)
- Team switch near time of d/c

System Errors
- No review for discrepancies between d/c orders and active med list
- No standardized MD/MD signout format

Day of Discharge Rounds
- Barriers to Discharge: What were they, how have they been met, if not met then proceed with SOAP presentation
- Medication Changes: confirm meds to be stopped and new meds on discharge; discuss need for PMD notification, pharmacy consult
- Follow-up Plans: Confirm ordered and arranged
- Pending Tests: Note pending tests and plans, notify PMD as needed
- Home Care/SNF Orders: ensure orders in, PMD notified

What can hospitalists do to help prevent similar adverse events in the future?

- Review d/c meds by Previewing the AVS in the “Discharge” APeX tab
- Champion and use “Day of Discharge Rounds” (created by Michelle Mourad) with real-time team review of d/c med rec if possible
<table>
<thead>
<tr>
<th>FY2017 True North Quality Metrics</th>
<th>FY2016 Baseline</th>
<th>July</th>
<th>Aug</th>
</tr>
</thead>
<tbody>
<tr>
<td>#SleepVitals Discharge ≥45% of patients with sleep promoting TID vital signs (8 out of 12 months)</td>
<td>15%</td>
<td>33%</td>
<td>48%</td>
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<tr>
<td>#DeliriumOrder Complete delirium order set for Nu-Desc positive patients within 12 hours (4 out of 6 months)</td>
<td>APeX report in progress</td>
<td>No data</td>
<td>No data</td>
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<tr>
<td>#AVS Achieve ≥ 75% of patients with High-Quality AVS (6 out of 12 months)</td>
<td>69%</td>
<td>56%</td>
<td>61%</td>
</tr>
<tr>
<td>#MDexplain Achieve ≥ 77% score for HCAHPS “MD Explains in way patient understands” (6 out of 12 months)</td>
<td>77%</td>
<td>79%</td>
<td>In process</td>
</tr>
<tr>
<td>#MedRec Achieve ≥90% of patients who have had all medications reconciled before discharge (4 out of 12 months)</td>
<td>88%</td>
<td>87%</td>
<td>89%</td>
</tr>
<tr>
<td>#POLST Achieve ≥ 60% of patients (not full code) with POLST completion (8 out of 12 months)</td>
<td>55%</td>
<td>61%</td>
<td>67%</td>
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