Workshop Faculty

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Agenda

• What are handoffs?
• What are the consequences for poor handoffs?
• What are the best practices?
• How to teach them?
• Tools for feedback
• Measuring success
What is a handoff?

- Handoff = transfer of professional responsibility and information between physicians and nurses in a HIPAA compliant manner with a standardized approach

- A handoff is **NOT** an H&P....

- Rather, a handoff *briefly* conveys:
  1. Why the patient is here
  2. What is their current clinical condition
  3. What is the plan going forward...
Examples of Patient Handoffs

- Shift changes for nurses
- Temporary responsibility for staff (MD or RN) leaving the unit ex. Lunch break
- Physicians handoff patients when they go:
  - off shift (night)
  - off service (vacation/ change in rotation)
- Anesthesiologist reports to post-anesthesia recovery room nurse
- Nursing and physician handoffs from clinics to:
  - inpatient units
  - different hospitals
  - nursing homes
  - home health care agencies
What is a Handoff?

Consulting Service
Ward Nurse
Covering Physician
Pharmacist
Lab
Primary Care MD
ER Physician
ER Nurse
Failures in communication are the most common root cause of sentinel events reported to JCAHO.

Sentinel Event Statistics. Available at: http://www.jcaho.org
Handoff Errors Frequently Affect Patients and Physicians

- 7.5 Handoff related problems per 100 patient days
- Equals 1 error each day for every 13 patients hospitalized
- 20% resulted in adverse events to the patient
- 18% Near miss
- The rest of the incidents resulted in inefficient or duplicated care by cross covering physician

Horwitz et al Arch Intern 2008; 168(16):1755-1760
Poor Handoffs: What’s Missing?

• Clinical condition of patient at the time of handoff was omitted ex. persistent bronchospasm
• Recent or scheduled clinical events of the patient were omitted ex. Hypoglycemic event not signed out by daytime MD
• Failure to provide anticipatory guidance for likely clinical complications- What to do for potential complications?
• A “To-Do List/ Check List” was left out or incomplete- ex. Not signed out to check results of Brain CT

Horwitz et al Arch Intern 2008; 168(16):1755-1760
Poor Handoffs: What’s Missing?

- A complete plan was not provided - tasks were assigned without the covering physician being told how to complete them ex. DKA
- The rationale for the treatment plan was not explained ex. Reason for MRI

Horwitz et al Arch Intern 2008; 168(16):1755-1760
Joint Commission “Best Practices”
National Patient Safety Goal 2E

The hospital’s process for effective handoff communication includes:

1. A method to verify received information including:
   - **repeat-back** (↑ memory & accuracy of info received)
   - **read-back** (↓ risk for poor communication)

2. An opportunity for receiving provider to review relevant patient data, including prior treatment

3. **Limit interruptions during handoffs:** ↓ the risk of poor handoff
   - Notify the nurses of your handoff time “7AM and 7PM” so they are trained not to disturb you.
   - Invite the nurses to handoff with you and them a copy of your handoff
Joint Commission & Society of Hospital Medicine “Best Practices”

1. Required verbal interactive communication between off-going and ongoing provider:
   • Should be face to face except rare occasions
   • Receiver appreciates inflections in voice to emphasize/ de-emphasize important info
   • Question and answer session

2. Up to Date information regarding condition, care, treatment, medications, services, and recent or anticipated changes:
   • What is the plan/ working diagnosis? “We think sepsis is from UTI given chronic Foley- however, the CVP line cannot be excluded”
Joint Commission & Society of Hospital Medicine “Best Practices”

2. **Up to Date** information continued

- **Focus on current clinical condition**
  “Today she spiked a fever”
  “At 5PM she was comfortable on 2L NC getting breathing treatments every 4 hours., all cultures (-) x 48hrs. On day 3 of 8 of Cefipime & Vanco Pharmacologic DVT prophylaxis”

- **Focus on changes in meds- errors 80% of time**

<table>
<thead>
<tr>
<th>Past Events</th>
<th>Instead of</th>
<th>Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Went to OR 2 days ago</td>
<td></td>
<td>Went to OR 6/24/09</td>
</tr>
</tbody>
</table>

- **Write dates for clinical events**

<table>
<thead>
<tr>
<th>Future Events</th>
<th>Going to OR in AM for Appy</th>
<th>Going to OR 7/3/9 for Appy</th>
</tr>
</thead>
</table>
Joint Commission & Society of Hospital Medicine “Best Practices”

2. Up to Date information continued

- **Focus on baseline and changes from this:**
  - Lab values: “Baseline Creatinine is 1.0, now 1.8”
  - Mental status “Baseline L Hemiplegia is mild 4+”
  - Radiographic findings “Has a chronic L Pleural Effusion”

- **Other things to consider:**
  1. Code Status
  2. Family contact info
  3. Referring MD/PCP
  5. Which consultants on case AND what it their opinion
Society of Hospital Medicine
Best Practices

1. Tracking system to document the correct physician caring for a specific patient after staffing change

2. All patients that are handed off are included
   - All patients expected should be on handoff i.e. direct admissions or transfers pending from other hospitals
   - Patients discharged that day should be on handoff: - discharges are sometimes held
     - something happens at home with the discharged patient, who calls back to the hospital for help.
   - Remove them next AM when you verify they are physically gone.
3. Sickest patients are given priority
   1. “Let me start with my sickest patient, Mr. Martinez who is really short of breath and full code…”
   2. Spend more time going over the details of their care
   3. Sickest Patient label on the handoff document
4. Anticipatory Guidance- “If/ Then”
   1. Guidance is given to receiving physician on what to expect or do in case complications develop.
   2. Drop down menu for templates
      ex. Respiratory status “If the patient develops SOB, then increase frequency of breathing treatments from Q4 hrs. to Q3 hrs. and reassess a few hours later”
Society of Hospital Medicine
Best Practices

5. Action items highlighted (i.e. To-Do List/Checklist)
   - “Check CBC at midnight. Last Hb 9” Then, tell them what to do about it!! “Transfuse 2 U PRBC if falls below 8”
   **Checklists document closing the loop**

6. Handoff is available in a centralized location
   ex. HIPAA compliant secure website, quiet room for handoff

7. A standard computerized template is updated and printed out prior to each handoff – An IT solution does not replace verbal handoff
8. A formally recognized handoff policy should be instituted with a set time at the end of a shift or change in service by each department.

9. Training for new users on the proper way to perform a handoff for your specialty.

10. Formal feedback on handoffs from faculty and peers.

- ACGME Core Competencies of Communication and Professionalism.
Creating a Handoffs Quality Improvement Task Force in Miami

How do you know a handoff deficit exists?
What does your **needs assessment** show?
1. Are there documented sentinel events?
2. Resident satisfaction with process
3. Faculty satisfaction with process
4. Clinical information missing? Defective template?
5. Bad written or verbal handoffs (or both?!)
6. Feedback from Nursing?
Creating a Handoffs Quality Improvement Task Force at Miami

- What is your goal in creating this task force for handoffs?
- How will you measure your success?
- Who will be part of your team?
- Create your Mission and Aims Statements
- How will you give feedback to front line practitioners i.e. residents/ students/ non-housestaff hospitalist teams
### At University of Miami Hospital

**UM Hospital**

<table>
<thead>
<tr>
<th>Pt. Name</th>
<th>Admission Date</th>
<th>Diagnosis</th>
<th>Active Consults</th>
<th>Room #</th>
<th>Scheduled Medications</th>
<th>PRN Medications</th>
<th>Lines and Catheters</th>
<th>Allergies</th>
<th>Active Conditions</th>
<th>Chronic Stable Conditions</th>
<th>Hospital Events</th>
<th>Studies/Imaging/Blood Cultures etc. to be done</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1133</td>
<td>2/3/2011</td>
<td>64 yo homeless male with draining diabetic left foot abscess, now post debridement by podiatry, to receive 4-6 weeks of IV antibiotics</td>
<td>Podiatry</td>
<td>2/3-1133</td>
<td>Tynelol 550 mg po q6h pm</td>
<td>Tramadol 50 mg po q6h pm</td>
<td>Penicillin 10 mg PO daily</td>
<td>Diabetes mellitus</td>
<td>HTN</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Medical Notes:**

- 2/4: pus collection to site of left foot to be drained by podiatry. Foot X-ray: no evidence of osteomyelitis.
- 2/10: wound vac.
- 2/17: increased levemir to 60 U sq qhs 2/25: iv at 3/21, as per podiatry.
- 2/28: PICC line is not working properly.

**Team:**

- [ ] Diabetic level, routine labs q2days
- [ ] Adjust insulin as needed
- [ ] Monitor bp and go up an nitroglycerin to 40 if needed
- [ ] None
- [ ] None
- [ ] None

**Orders:**

- [ ] None
- [ ] None
- [ ] None
- [ ] None

**Follow-up:**

- [ ] None
- [ ] None
- [ ] None
- [ ] None

**Notes:**

- [ ] None
- [ ] None
- [ ] None
- [ ] None
At Jackson Memorial Hospital

**TEAM 1B**

**Resident:** Alejandro Masieloo (c) 305-951-1662  
**Intern:** Sean Warsch 855-405-2130, p2358  
**Student:** Daniel Young 516-353-0384  
**Observer:** Estela Mogrovejo 786-985-4977

**Attending:** Dr. Scalese

**Pager:** 305-659-7633  **Cell:** 786-301-8700  **Office:** 305-243-2864  **Home:** 305-532-4201

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**TEAM 1A**

**Resident:** Ed Mezehrane (c) 305.450.5582 (p) 2636  
**Intern:** Jules Maria

**Chief Resident after hours:** Marcela

**Night Relief Pager:** 6605  **Computer Lab:** 5-5554  **ER Case Manager:** 0930

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**FLOORS:** SW5 5594 / SW6 8456 / SW7 3-1449 / WW5 7011 / WW6 6181 / WW10 6265 / WW11 6499 / WW12 6558 / WW14: 57556 / MICU 7100 / CCU 6494 / Floor Comp Lab 5566

**CONSULTS:** GI 272-4040 / Nephro 750-2731 (odd mm) 750-2732 (even mm) / Onc 212-4768 / Cards 0742 or 9753 or 305-732-4390 / Vascular 2055 / Heme 212-4784 / GU 0100 / ID 681-3165 or 305-996-0007 (onc) / Endoc 250-3880 / GYN 738-2869 / ENT 0892 or 0902 / Pulmonary 581-3000 / Rheum 750-0903 / N-surg (brain) 0204 / N-surg (spine) 0311 / CT Surg: 0538 / Hematology 305-291-0892 / Dem 305-760-1688 / Neuro 0591 / Trauma 1754 / EJ 3055 / EJ 0908 or 0997 / EJ 0547 / Ortho 2115 / Psych: 5-5354 or 1560 / Dr. Harrington 2080-0377 / Genetics: 305-331-3023 / MOD 1535 Hospice Care / NW5 5594 / Path 57065 / PNI 0284 / PCC 5594 / Fax 585-7458 / CT


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<table>
<thead>
<tr>
<th>Patient Info</th>
<th>History</th>
<th>Medications</th>
<th>Imaging/Labs</th>
<th>To Do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2711723</strong></td>
<td>SW532</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DOA:</strong> 2/16/11</td>
<td><strong>Full code:</strong> NKDA</td>
<td><strong>Student:</strong> Dan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Info</th>
<th>History</th>
<th>Medications</th>
<th>Imaging/Labs</th>
<th>To Do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>44 yo male w/ HIV since 2003, poor compliancy w/ HAART, came to ER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Patient Info:**

- **26 yo male with HIV (CD4 7) presented to ER w/ worsening dyspnea on exertion, CP, and cough for 1 month. Found to have B/L pulmonary interstitial infiltrates and left sided pneumothorax.**

**Medications:**

- Bacitracin DS 2 tabs PO q6hr (2/16-3/9)
- Truvada 1 tab PO QD
- Sustiva 600mg PO QD
- Zithromax 1200mg q week
- Seneca-docusate BID
- Lactulose 30mL QD PRN
- Lactulose opth sm
- Percocet 10 qhrs prn pain
- Fragmin 5000units SQ QD
- Phenergan 25mg pr Q6hr PRN
- NVF: 125mL/hr NS
- d/c ed: prednisone (2/16-21)
- Ceftriaxone 2g IV Q6hr (3/3-5)
- Vancomycin 1g IV Q12hr (3/3-5)

**Imaging/Labs:**

- CXR (3/5): Slight increase in size of the left apical pneumothorax
- FeNa: 0.7, cortisol normal
- 2/27: BC x2, UC x NG

**To Do:**

- CT (1/20/10)- 2 pulmonary nodules and suspicious Node of Rouviere
- NTD: CT surg to take pt to OR on Weds
- 1-flu CXR
- 250 SFAN for 30 days of HAART therapy on d/c, have CSM clear up social-security # mistake with Ryan White program
Patient admitted to hospital by MD

Shift/Service change by MD

MD enters patient clinical information on handoff template

Deficits in patient clinical information in online handoff template

Suboptimal verbal MD to MD handoff

Medical error with harm

Good catch

MD does not place patient on handoff template

MD unaware of patient

Good catch

Patient handed off with correct information

Receiving MD is clear on plan of care and cares for patient after seamless transition

Deficits in ≥1:
- Reason for admission
- Illness severity
- Active/unstable medical problems
- Current condition at handoff
- Anticipated problems
- Checklist for next shift

Medical error with harm

Good catch
Internal Medicine Handoffs Team

Guidance Team/Leadership

IM Vice Chair Quality and Safety

UHealth Director Quality & Safety

UHealth Senior Executive Dean Quality and Safety

Project Leader

Reporting Direction

Dr. Manjarrez

Facilitator

Project Team

Participation Ownership

4 Abstractors

2 JMH CMR’s

1 UMH CMR

IM Program Director

JMH Residents

UMH Residents

Front Line Workers

Fundamental Process Knowledge

4 Abstractors

2 JMH CMR’s

1 UMH CMR

UMH Residents

APD’s
General statement with background and tasks to achieve:

• Handoffs of hospitalized patients represent critical transition points in patient care.
• Poor quality handoffs carry the risk of poor outcomes for patients and physicians.
• No practice guidelines exist for performing handoffs
• By standardizing the elements of the verbal and written handoff with:
  1) a standard computerized template across the facilities
  2) a script of required clinical information
  3) Feedback to the intern with real examples from their own sign-outs

We expect to decrease variation in practice patterns, decrease confusion among practitioners, and improve clinical outcomes in the long term.
Aim Statement

Builds on Mission Statement with specific metrics to achieve and due date:

• Practice patterns regarding handing off of hospitalized patients at shift or service change is inconsistent among physicians.
• The goal of this project is to standardize the elements of the handoff of hospitalized patients by internal medicine residents according to best practices
• We expect to comply with 85% and above for our 10 metrics by June 23, 2011.
### Proposed Verbal Handoff Script DPAC-Q

<table>
<thead>
<tr>
<th>Competency</th>
<th>Present or absent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
</tr>
<tr>
<td>• Identification</td>
<td></td>
</tr>
<tr>
<td>• <strong>Illness severity</strong></td>
<td></td>
</tr>
<tr>
<td>• Code Status</td>
<td></td>
</tr>
<tr>
<td><strong>Problems</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>Reason for admission</strong></td>
<td></td>
</tr>
<tr>
<td>• Active/ Unstable</td>
<td></td>
</tr>
<tr>
<td>• Stable/ Chronic</td>
<td></td>
</tr>
<tr>
<td>• Allergies</td>
<td></td>
</tr>
<tr>
<td>• <strong>Current Condition at Handoff</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>Anticipatory guidance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Checklist for next shift</strong></td>
<td></td>
</tr>
<tr>
<td>Questions asked-Read back/ repeat back</td>
<td></td>
</tr>
</tbody>
</table>
Handoffs Preintervention Pareto Chart

- Illness Severity
- Condition at Handoff
- Checklist
- Anticipatory Guidance
- Code Status
- Reason for Admission
- Allergies
- Chronic Condition
- Active Conditions
- Demographics
## Standard Handoff Template

### Residents call this “Last 24” (Night Relief)

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Problems &amp; Reason for Admission</th>
<th>Medications</th>
<th>Bags and Studies</th>
<th>Labs</th>
<th>Anticipatory Guidance &amp; Checklists</th>
</tr>
</thead>
<tbody>
<tr>
<td>2041381</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOA: 4/4/12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All: NKDA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code: FULL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WW 1505</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Problem List:**

1. **Urosepsis/pyruvi:** bands on CBC, possible intraabdominal pathology, cultured 4/4
2. Acute kidney injury, r/o rejection vs sepsis
3. Anemia
4. Hypovolemic
5. Hypernatremia
6. Hyperlipidemia
7. Diarrhea (4/6; resolved)
8. Symptomatic bradycardia secondary to labetalol dose 4/15 am

**Antibiotics:**

- Bacitracin SS 1 tab po MWI
- Levodopa 500 mg iv once (4/10)
- Levoquin 250 mg iv qd(4/11-4/13)
- Levaquin 750 mg po q48h (4/13-4/24)

**Immunosuppression:**

- Prograf 6 mg po q12h
- Myfortic 360 mg po BID

**Scheduled:**

- Clonidine 0.1 mg po TID
- Labetalol 200 mg po tid
- Nifedipine ER 30 mg po BID
- Magnesium Oxide 400 mg po bid
- Crestor 20 mg po qd
- Noloxon 40 mg po qd
- Vitamin B12 100 mcg po qd
- Folic Acid 1 mg po daily
- Xanax 0.25 mg po qd
- Ferrous sulfate 325 mg po TID
- Colace 100 mg po BID

**PPN:**

- Tranxadol 50 mg po q8h PRN pain

**PPX:**

- Heparin 5000u SC q8h
- UF: none

**D/C:**

- Cefzil 250 mg po bid
- Bivalir 30 ml po tid
- Cefepine 1 g iv q24h (4/5-4/10)
- Vancomycin 1 g iv x 1 (4/5)
- Prednisone 10 mg po qd

| 4/5 CXR: no pulmonary edema, no infiltrates |
| 4/5 CT Abdomen: splenic kidney enlarged, complex cysts concerning for infection, mild hydro, rect aspirated for aspiration of upper pole cystic |
| Urine culture-E.coli |
| Repeat UA showed infection, but UC neg. |
| 4/15 EKG wnl |

**Anticipatory Guidance:**

- **Cr 5.2 (outpatient labs).**
- **4/3 prograf 1.1 (goal 4-8).**
- **4/4 Admission: hgb 7.9, bun 79, Cr 6.22, Na 121, bicarb 12**
- **4/5 AM: wbc 6.7 (10% bands), hgb 6.7 > transfused 2u prbc (4/5), na 119, bicarb 9, bun 80, cr 5.11.**
- **UA: cloudy, 100 prot, 1 blood, 500 leuk est, 173 rbc, > 182 wbc, 4+ bacteria, wbc clumps 4/4 RBCs neg, UCx > 100k CFU of GNR & GPC**
- **4/5 PM: wbc 8.2 (bands), na 121, bicarb 13 (8/2 am), bun 78, Cr 5.1.**
- **ABG: 7.37/19/120/11**
- **LDH 469, tiapto 364 (elev), Retie 0.6 (low)**
- **4/14: BUN 24, Cr 1.8, Na 129, bicarb 20, Hgb 9.8, prograf level 5-9**
- **4/15: BUN 26, Cr 2.02, Na 130, Bicarb 25, Hgb 9.7, Prog 6.1**

**Condition at Handoff:**

- Comfortable in bed.
- 4/15pm clindamycin & labetalol held due to bradycardia & hypotension. AVSS currently & on tele.

**Team:**

- [ ] note
- [ ] 1u AM labs, PSA
- [ ] 1u prograf
- [ ] 1u Miller labs
- [ ] 1u UN and CR in pigtail fluid
- [ ] IR
What about feedback?

Dear Dr. __________,

The Department of Medicine Handoffs Task Force in collaboration with the Department of Medicine Internal Medicine Residency Program has been reviewing the quality of handoffs. As you recall, it was stated during the instruction video on improving handoffs that these would be reviewed. The Task Force is composed of 5 individuals who are reviewing written handoffs and collecting data on performance for the Department of Medicine- it is a new ACGME requirement. The mission of the Task Force is to improve handoffs across the residency. As such, we are in the process of reviewing all handoffs, prior to taking the initiative across the medical school.

We would like to give you feedback and suggestions for improvement. We will review your handoffs again before the end of the rotation.

- We reviewed ___ days worth of sign-outs.
- Your average daily census was ___ patients signed out.
- We recognize that many things are communicated in the verbal handoff that are not on paper, but the written sign-out serves as a template for an excellent verbal one.

There are 10 metrics which were discussed:
You performed well in the following areas:
Demographics, code status, active problems, chronic problems, allergies.
The following areas were identified as areas for improvement:

- X
- Y
- Z

Thank you for your efforts to improve quality of care to our patients by giving your best effort to give high quality handoffs.

Sincerely,

Efren C. Manjarrez, M.D., F.H.M.
UHealth Handoffs Task Force Team Leader
Assistant Professor of Clinical Medicine
Associate Chief, Division of Hospital Medicine
University of Miami Miller School of Medicine
Feedback

• Who gets feedback letter?
• Who gets a copy of the letter?
• How frequently will you give feedback?
• What other forms of feedback are there?
What happened in Pittsburgh?
Evaluation and Feedback on Handoff

- Once every other week faculty members evaluated intern written handoff using the “sign-out” checklist.
- Faculty members critiqued written handoff and noted any deficiencies/areas of weakness.
- Faculty met face-to-face with interns and gave constructive feedback.
- The whole process took roughly 15 minutes per intern (every 2 weeks).
  - 10 minutes to critique sign-out
  - 5 minutes for feedback
Date: 
Intern Name: 
Attending Name: 

<table>
<thead>
<tr>
<th>Please evaluate your intern’s sign-out. Please check off whether the following parameters are present.</th>
<th>Patient Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code status is present in the correct location?</td>
<td></td>
</tr>
<tr>
<td>The sign-out includes a brief summary statement that reflects the reason for admission and relevant care to date?</td>
<td></td>
</tr>
<tr>
<td>Major patient problems are identified in the sign-out?</td>
<td></td>
</tr>
<tr>
<td>Information in sign-out is up to date?</td>
<td></td>
</tr>
<tr>
<td>The sign-out is well formatted so distinct issues are clearly separated, bulleted, and/or numbered?</td>
<td></td>
</tr>
<tr>
<td>Specific dates are used to report events rather than ambiguous time frames?</td>
<td></td>
</tr>
<tr>
<td>The sign-out is easy to read?</td>
<td></td>
</tr>
<tr>
<td>The sign-out includes anticipatory guidance for predicted patient events? These are often called if/then statements. (Example: If patient gets short of breath, then give lasix.)</td>
<td></td>
</tr>
<tr>
<td>Tasks in the To-Do List are appropriate?</td>
<td></td>
</tr>
</tbody>
</table>

**Summary Score Guidelines**

- Superior Rating = All Items Checked for Each Patient
- Satisfactory Rating = 1-2 items not Checked for 2-3 Patients
- Unsatisfactory Rating = 3 or more items not Checked for Most Patients

Summary Score:  1  2  3  4  5  6  7  8  9

Unsatisfactory  Satisfactory  Superior

Please use the back for comments on areas for improvement.
Evaluation and Feedback on Handoff

• Faculty development consisted of a 30 minute orientation session to discuss handoff best practices.

• This was followed by a 10-15 minute refresherer twice a month.

• Done during a weekly hospitalist meeting (over lunch).
Does it work?

- Over 3 months we conducted a randomized clinical trial
  - Half of the general medicine teams got sign-out evaluation and feedback
  - Half of the teams that did not receive feedback
Does it work?

Control

Week 2
Handoff evaluated with checklist

Week 3

Week 4
Handoff evaluated with checklist

Intervention

Week 2
Handoff evaluated with checklist + face-to-face faculty supervisor feedback

Week 3
Handoff evaluated with checklist + face-to-face faculty supervisor feedback

Week 4
Handoff evaluated with checklist
Does it work?

• Use of the handoff checklist led to significant handoff improvements:
  – Percentage of handoff completed correctly improved to 87% (SD 15%) in the intervention group compared to 71% (SD 19%) in the control group \((P = 0.01)\).
  – The mean summary score of handoff at week 4 was 6.7 (SD 1.5) in the intervention group compared to 4.9 (1.9) in the control group \((P = 0.007)\).
  – Using regression analysis we calculated a 23% improvement in handoff content \((P = 0.005)\) and a 2.2 point improvement in overall summary score (on a 9 point scale, \(P=0.009\)).
1. Your *needs assessment*? How do you know a problem exists with handoffs?
Your turn

• Who will be part of your Handoffs Quality Improvement team?
Your turn

• Which metrics will you measure?
• How frequently will you measure them?
Your turn

Write a Mission Statement
Write an Aims Statement
Your turn

- How will you teach your curriculum?
- To Whom?
Your turn

• How will you give feedback to your learners? How frequent?
Summary

What we learned:
• What are handoffs?
• What are the consequences for poor handoffs?
• What are the best practices?
• How to teach them (2 successful institutions)
• Tools for feedback
• Measuring success