# Handoff Redesign to Reconnect and Reduce Burnout


Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Mitchell Ross MD, Susan McGirr MD, Justine Blum MD, Rachel Hensel MD, Alicia Clark MD

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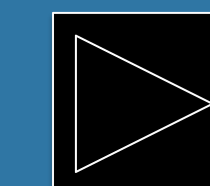


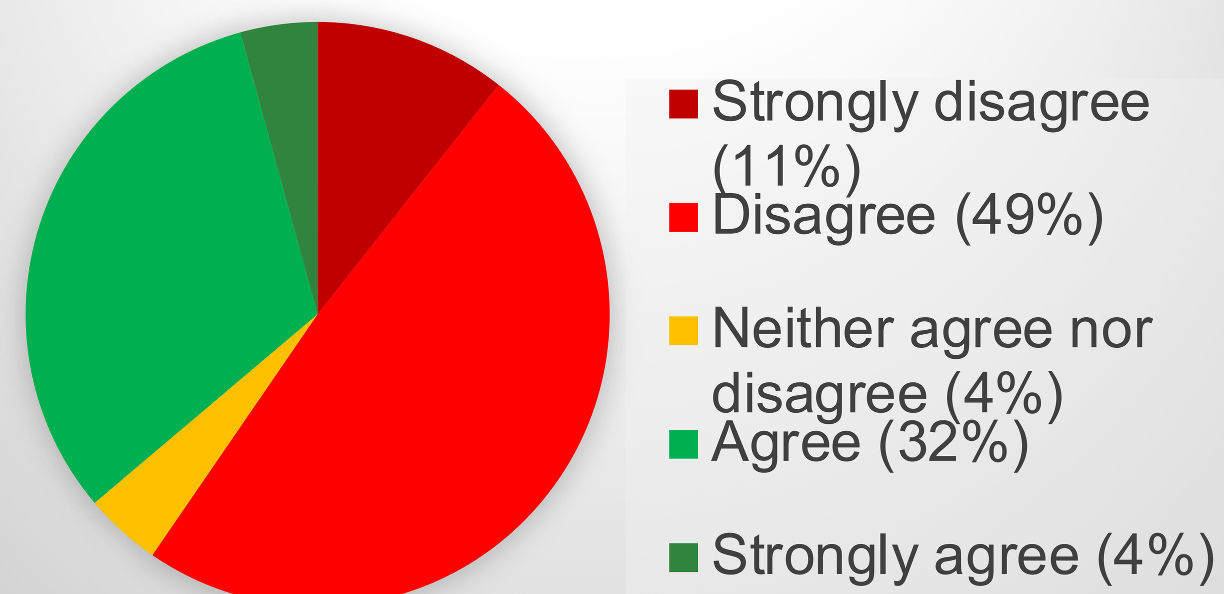
## Introduction

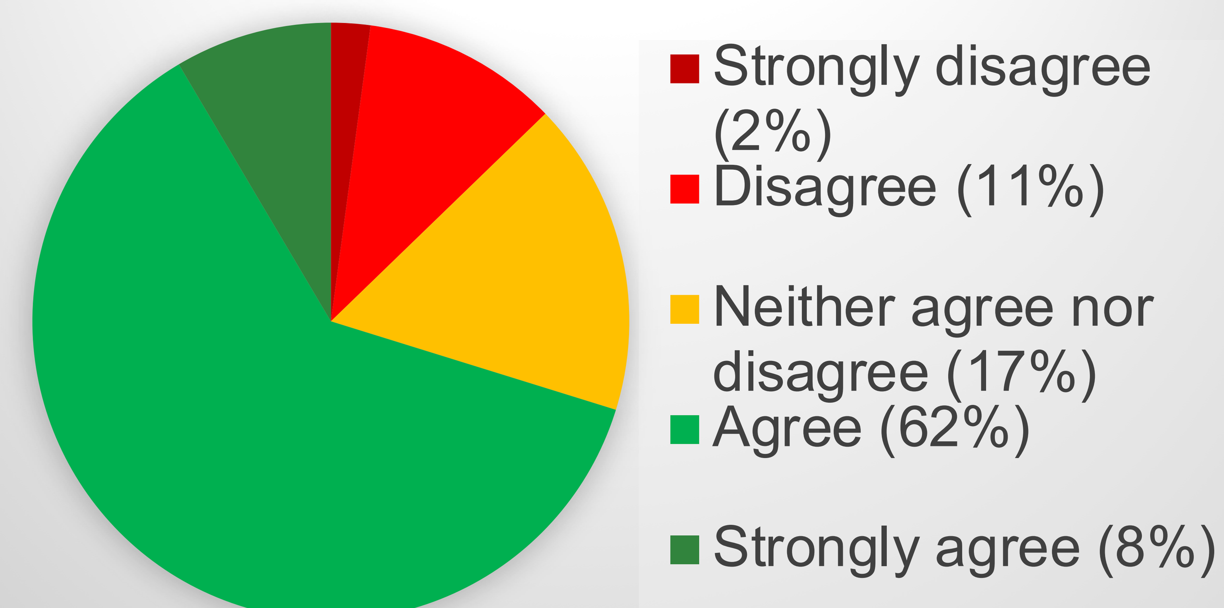
Handoffs between Hospitalists going off and coming onto service are frequent. Our prior process involved extensive written communication through multiple overlapping documents but did not require any verbal exchange. Burnout from a cumbersome written process was exacerbated by COVID-19, which also made it more difficult for colleagues to converse. By modifying the service signout process, **we aimed to improve efficiency and reduce burnout without sacrificing Hospitalist preparedness to assume patient care.**

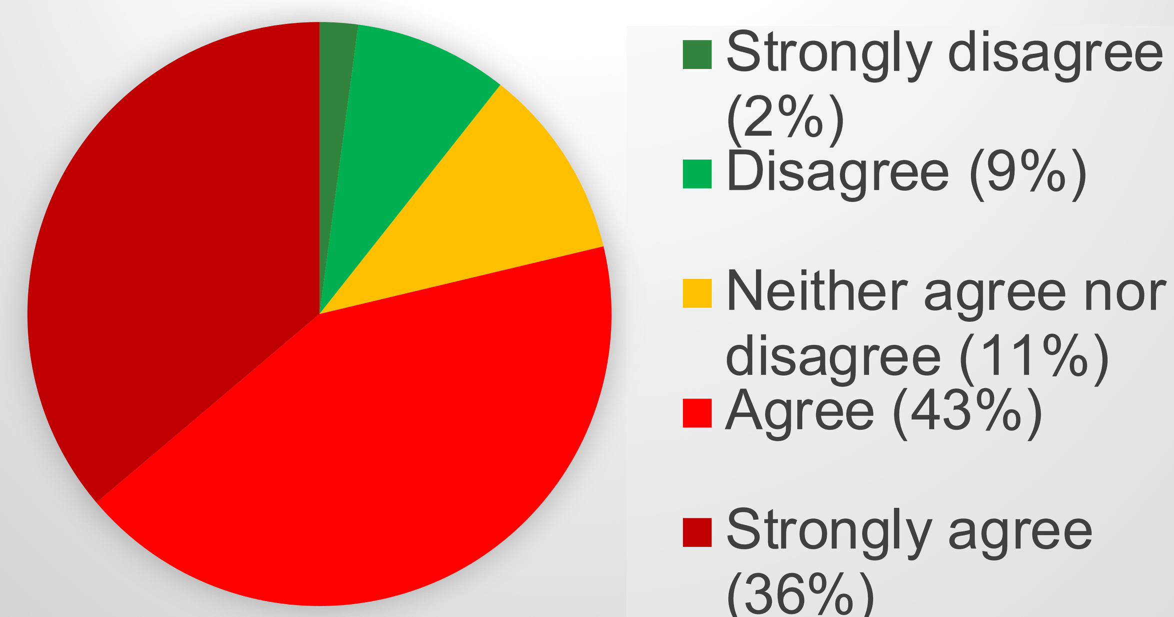
## Methods

First, Hospitalists were openly invited to discuss the current signout process, identify major problems, and offer possible solutions. All Hospitalists were sent baseline surveys, to which 47 responded. Based on the themes generated, we proposed a **modified process abbreviating much of the written communication and adding a 30-60 minute verbal handoff.** This modified process was then piloted over a four-week period among all Hospitalists providing direct patient care on the 12 Reisman medical unit. Participating providers were surveyed after both giving and receiving handoffs. 10-13 responses were generated per question.

## Pre-Intervention Survey

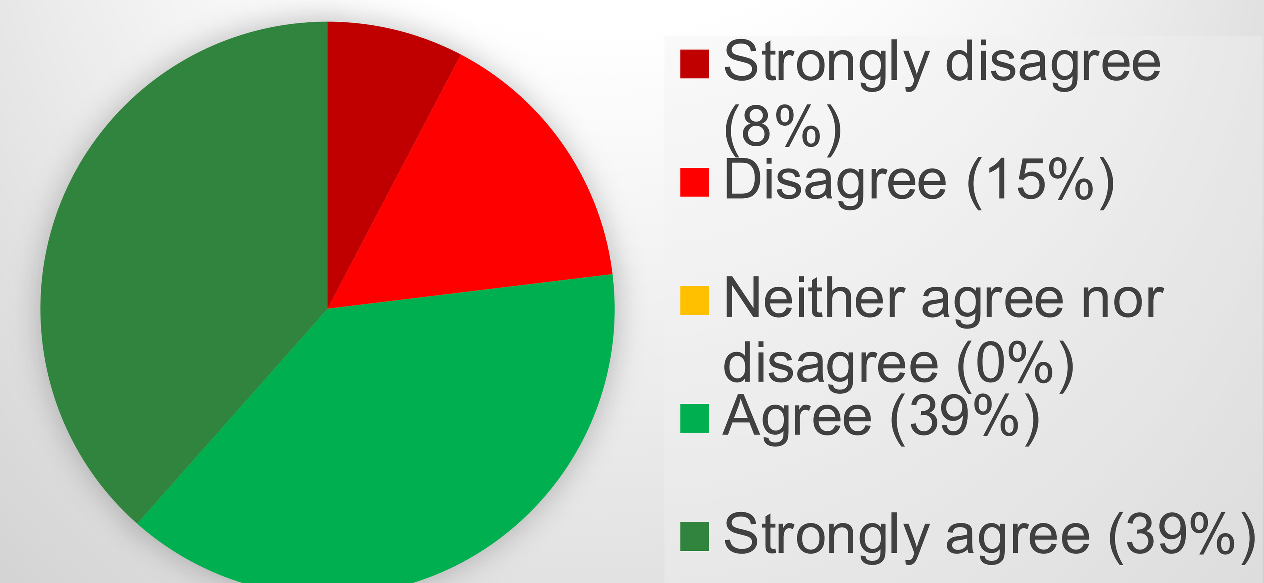


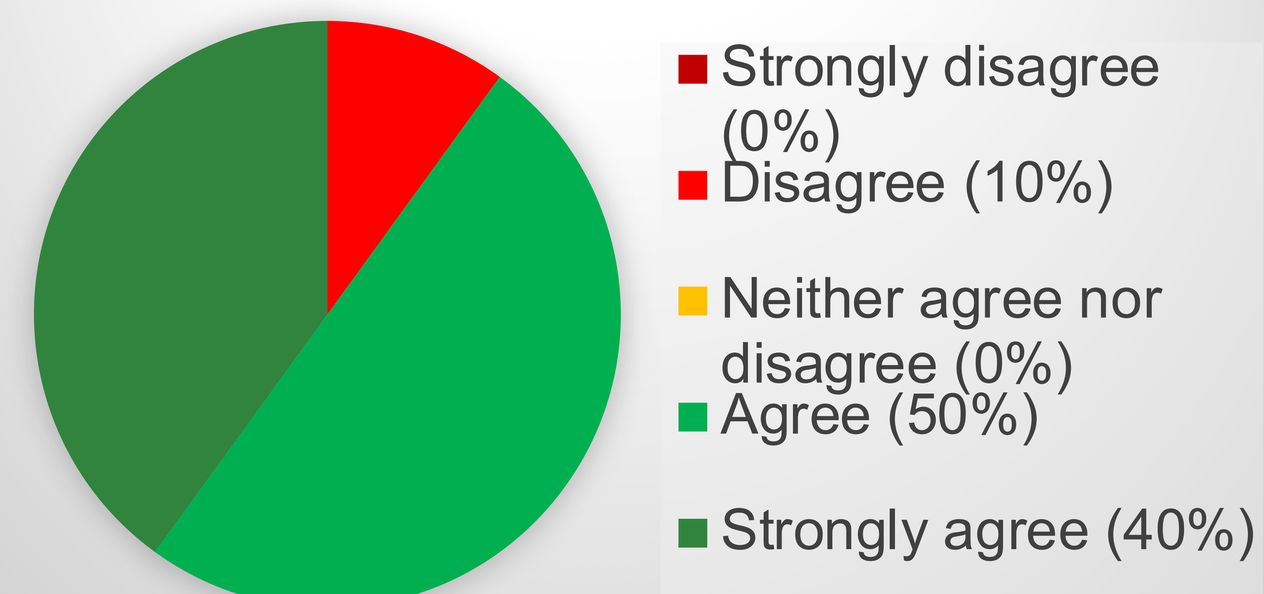



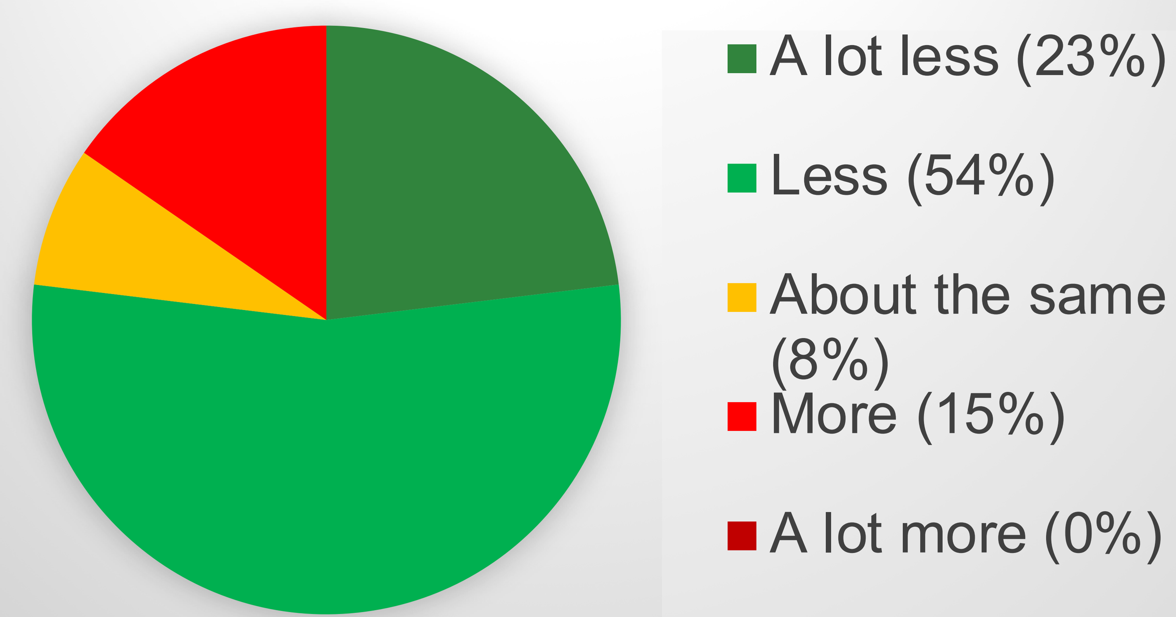




Figures 1-3. Survey responses regarding pre-existing signout process. N=47.

## Post-Intervention Survey




Figures 4-6. Survey responses regarding piloted signout process. N=10-13.

## Key Results

- More providers (77% vs. 36%) felt the piloted signout process was an effective use of time.
- Reduced estimated time by 12 minutes per patient.
- 90% of oncoming providers felt prepared to start after receiving a verbal handoff with an abbreviated written signout.
- The majority of providers (69-70%) preferred the modified signout process.
- 77% of providers going off service indicated the piloted process was "less" or "a lot less" likely to contribute to burnout.

## Opportunities

- Improved human connection
- Collaborative learning
- Peer to peer feedback

## Next Steps

- Implementation on all direct care (Attending only) services.
- Incorporate verbal handoff into teaching service signout.

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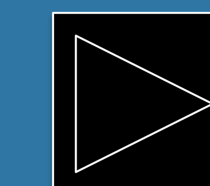

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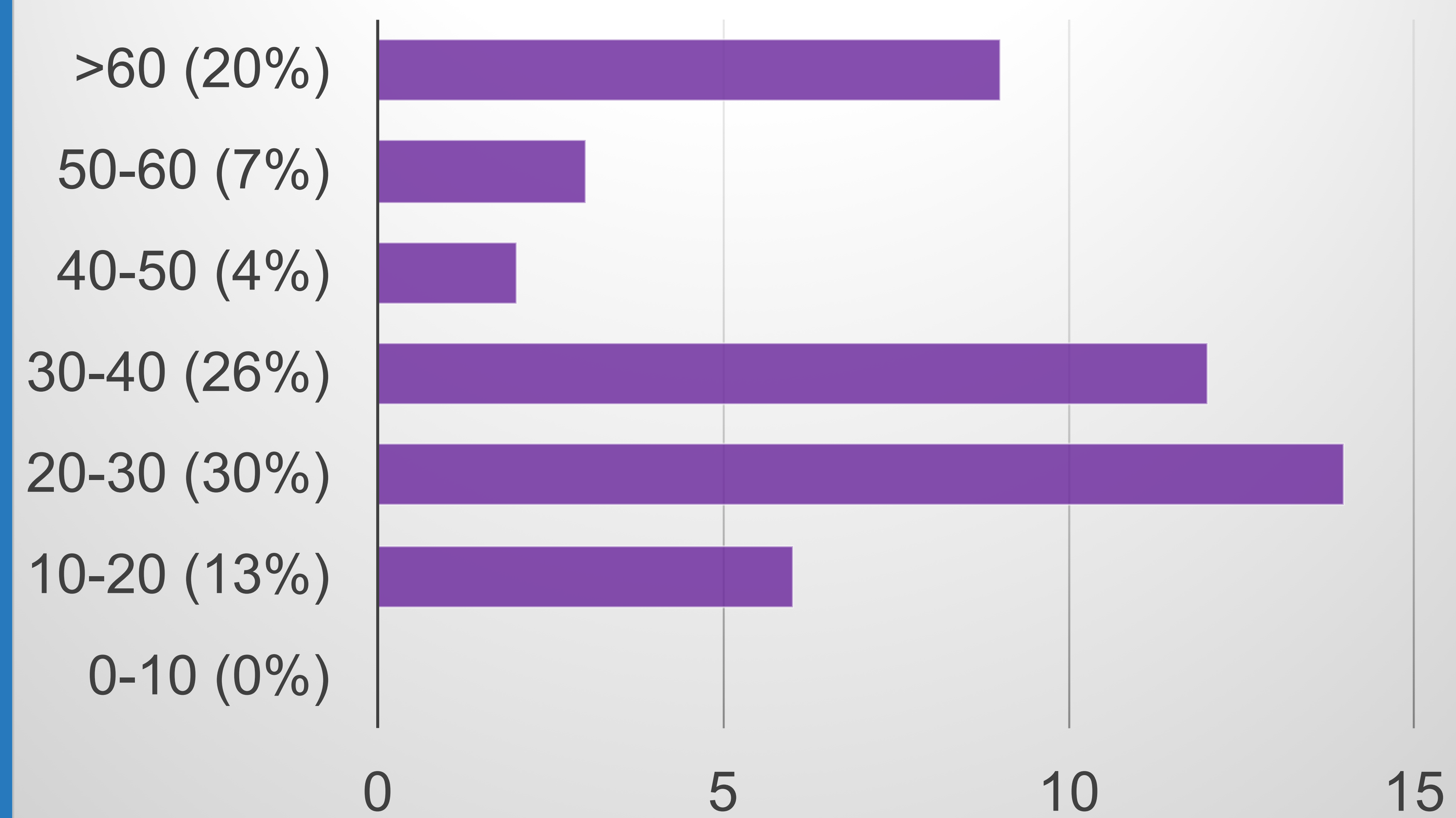


Figure 7. Estimated time per patient completing entire signout process. N=47. Typical census of 8 patients = 5 hours.

## Post-Intervention Survey

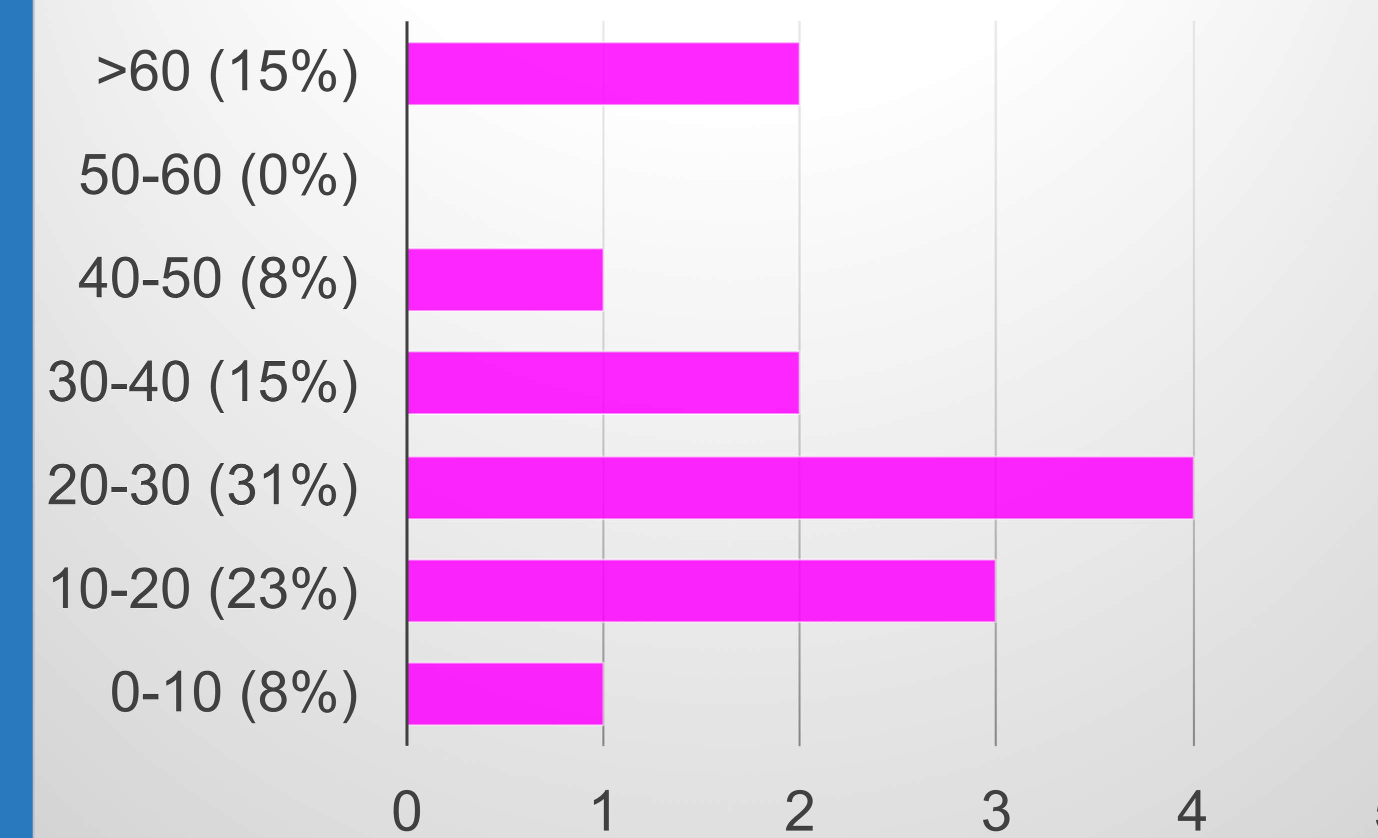


Figure 8. Estimated time per patient completing entire signout process. N=13. Typical census of 8 patients = 3.5 hours.

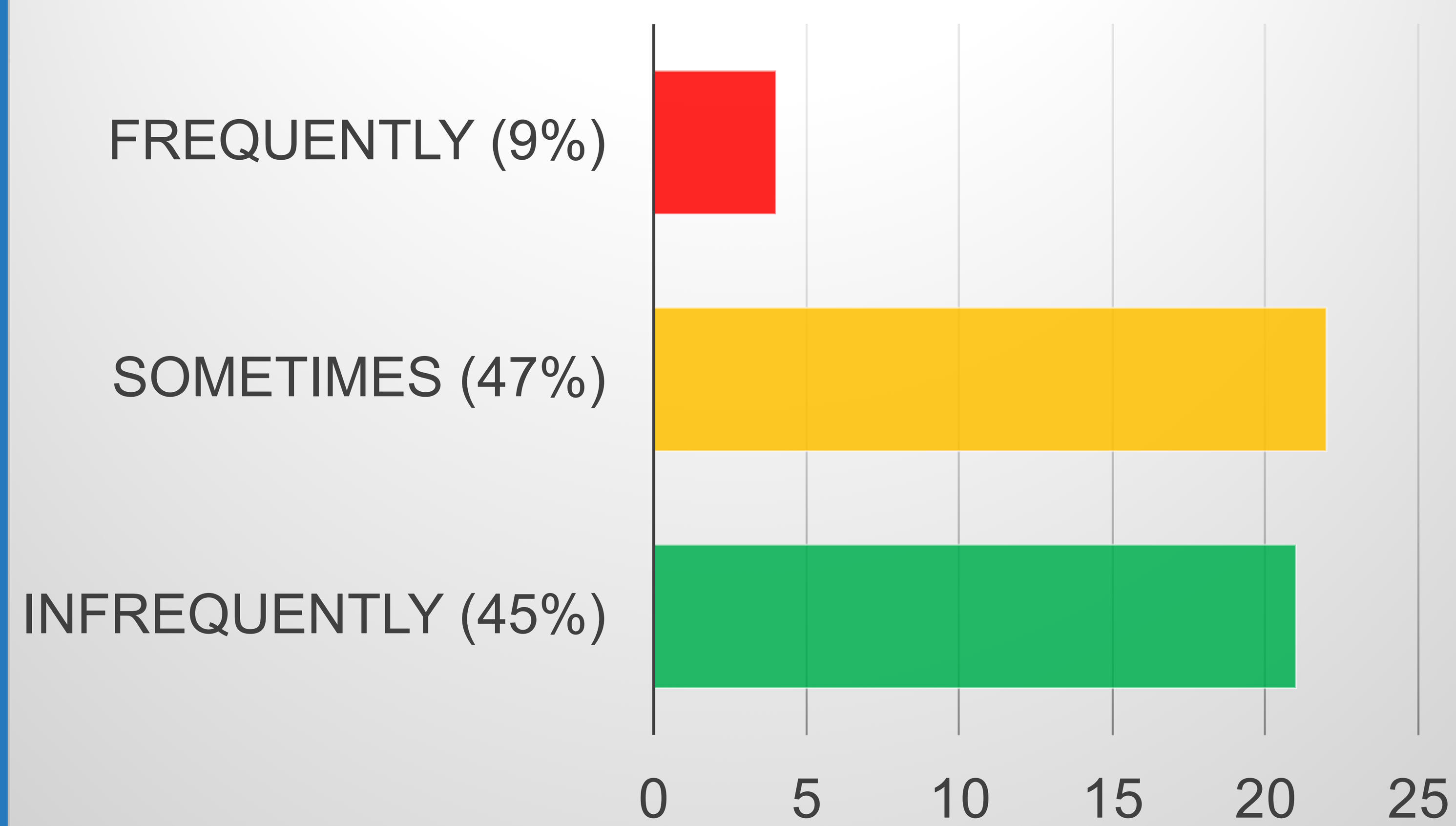


Figure 9. Estimated frequency of missed information with pre-existing signout process. N=47.

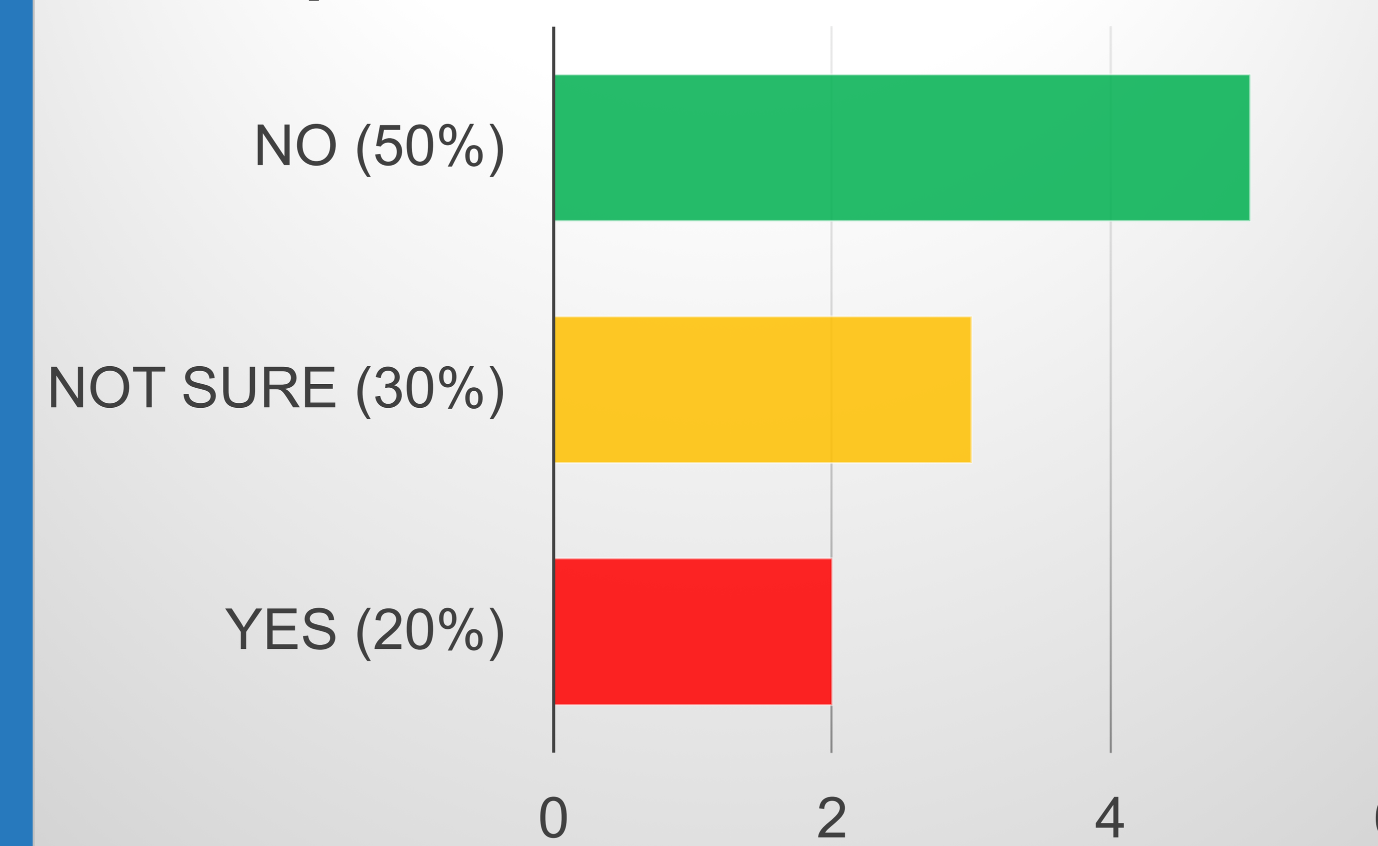


Figure 10. Oncoming providers' report of later discovered important information not covered with modified signout. N=10.

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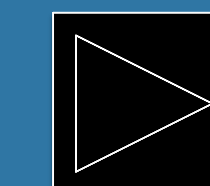

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## Provider Preparedness and Preferences

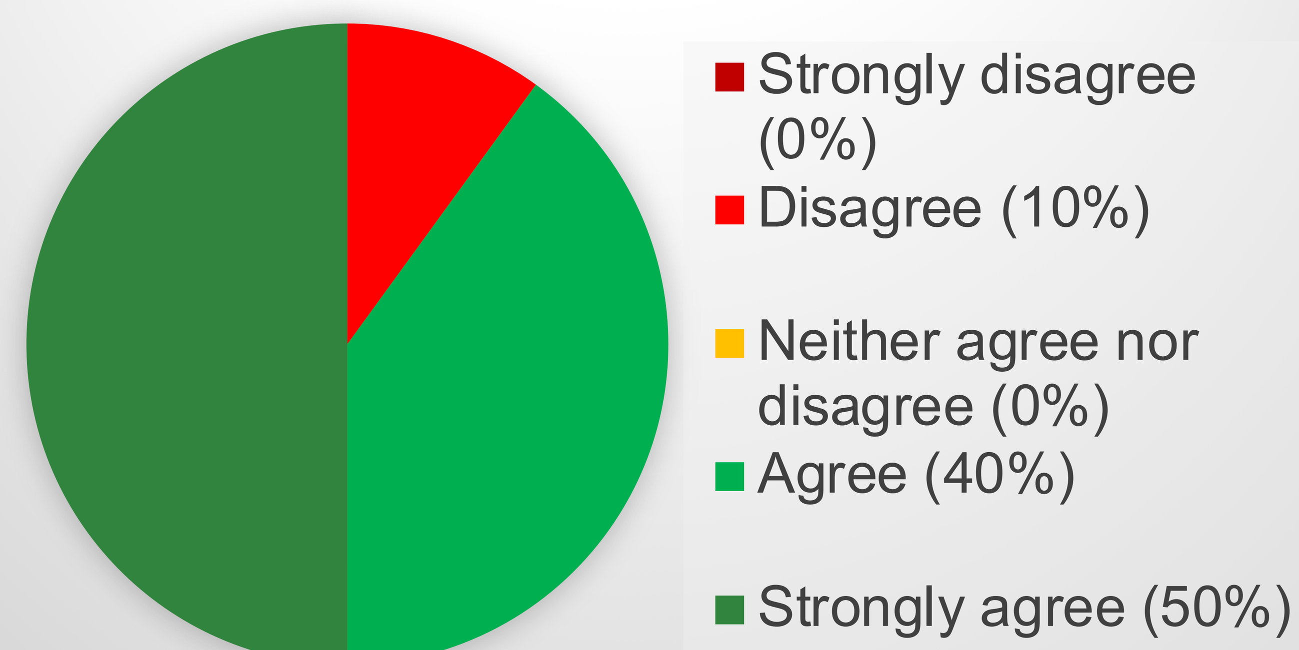


Figure 11. Oncoming providers' perceived preparedness after receiving modified signout. N=10.

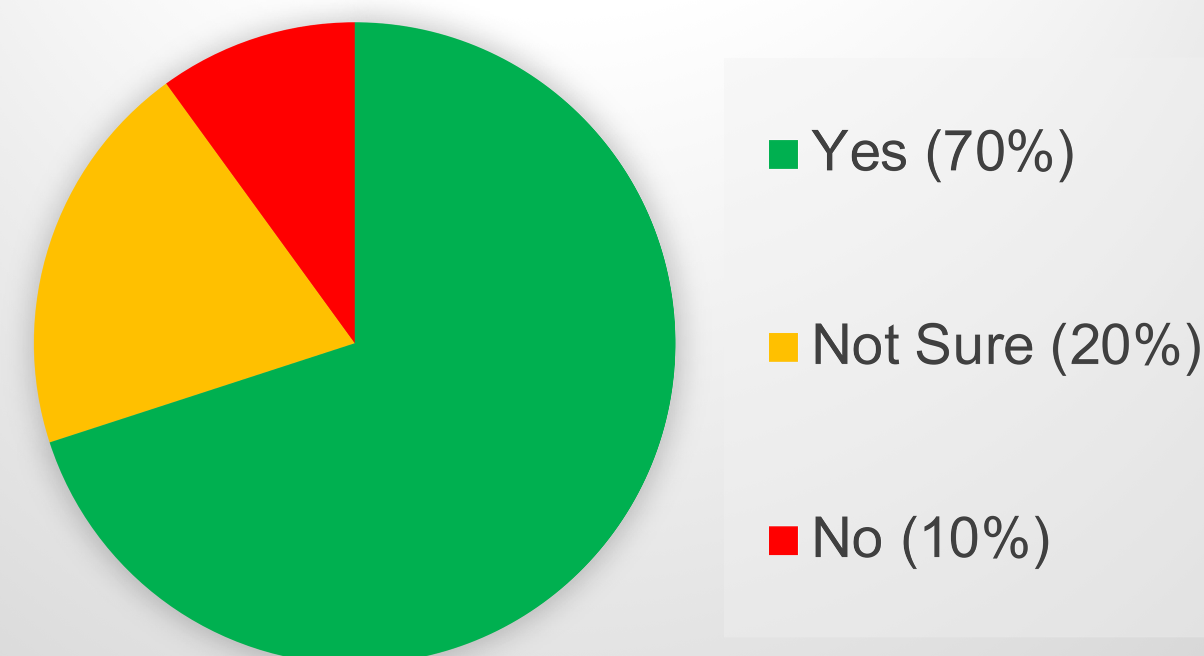


Figure 12. Oncoming providers' preferences for or against modified signout. N=10.

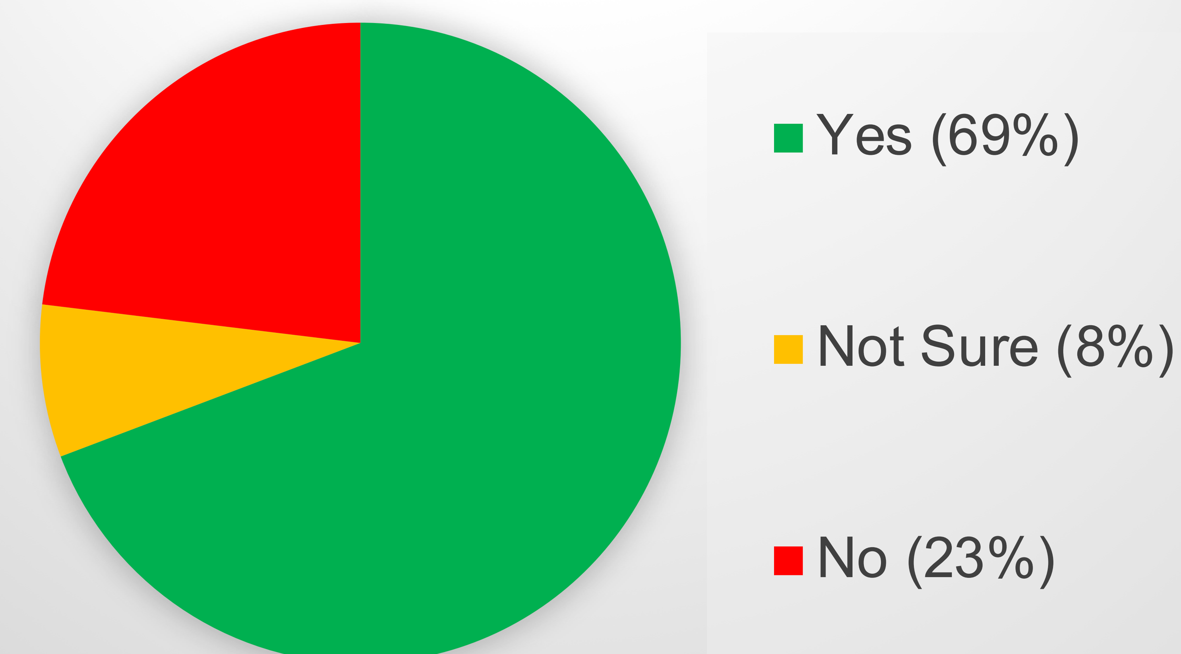


Figure 13. Offgoing providers' preferences for or against modified signout. N=13.

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# Warm Handoff Guidelines

| SHOULD | SHOULD NOT |
| --- | --- |
| Focus on the most complex patients | Simply repeat information already written |
| Express uncertainty: what's unknown and/or undifferentiated | Read directly from abbreviated written signout without adding context |
| Explain deviation from standard of care | Require the receiver to take notes |
| Include questions and clarifications | Be a one-way or lopsided conversation |
| Mention nuanced social issues | Be rushed or inconveniently timed |
| Ideally occur with medical record in view | Last more than an hour in most cases |
| Identify follow up communication needed | |