Facts about the Hand-off Communications Project

In 2009, 10 of the Center's collaborating hospitals and health systems began a project focused on ineffective hand-off communications. For the project, a successful hand-off is defined as a transfer and acceptance of responsibility for patient care that is achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another or from one team of caregivers to another to ensure the continuity and safety of that patient's care. A hand-off process involves "senders," the caregivers transmitting patient information and transitioning care of a patient to the next clinician, or "receivers," the caregivers that accept patient information and care of that patient. The leading health care organizations who participated in this project, together with the Center, examined their hand-off communications problems, and identified their specific causes for failures and barriers to ineffective hand-off communications. They then identified, implemented and validated solutions that improved their performance.

The TST® for Hand-off Communications

The universal experience of the health care organizations that built and tested the Targeted Solutions Tool® (TST®) for Hand-off Communications was that senders and receivers had very different expectations of what constituted a successful hand-off. Using the TST®, these organizations aligned expectations of the hand-off, developed a process for a successful hand-off, and fostered better relationships and communication among staff. Health care organizations that field tested the tool experienced the same success as that of the original 10 leading hospitals and health systems. Using the tool and the solutions from the Center's Hand-off Communications project, health care organizations reported an increase in patient and family satisfaction, staff satisfaction and successful transfers of patients. One health care organization reduced readmissions by 50 percent; another health care organization reduced the time it takes to move a patient from the emergency department to an inpatient unit by 33 percent. Health care organizations were able to complete their Hand-off Communications Projects in approximately four months, using minimal resources. In fact, no staff was added and only minor changes were made to the roles and responsibilities of existing staff. The Hand-off Communications TST®:

- Facilitates the examination of the current hand-off communication between two settings of care from the view points of both the senders and receivers involved in the process.
- Provides a tested and validated measurement system that produces data that support and drive the need for improving the current hand-off communication processes.
- Identifies areas of focus, such as the specific information needed for the transition that is being measured. For example, the information needed for a hand-off from the emergency department to an inpatient unit differs from that needed for a hand-off from a hospital to a skilled nursing facility.
- Provides customizable forms for data collection to fit the specific needs of the transition being measured.
- Provides guidelines to determine the most appropriate and realistic hand-off communication process for a given transition, while also empowering the staff involved in the process.

How targeted solutions are identified

Robust Process Improvement® (RPI®) is a fact-based, systematic, and data-driven problem-solving methodology that incorporates tools and concepts from Lean Six Sigma and change management methodologies. The original participating organizations used RPI® to identify the magnitude of specific problems that increase the risk of this event. They then pinpointed the contributing causes, developed specific solutions that were targeted to each cause and thoroughly tested the solutions in real life situations.

Addressing the causes for unsuccessful hand-offs
The solutions from the Center use the acronym **SHARE**, which addresses the specific causes why hand-offs are unsuccessful. **SHARE** stands for:

Standardize critical content, including:
- providing details of the patient's history to the receiver
- emphasizing key information about the patient when speaking with the receiver
- synthesizing patient information from separate sources before passing it on to the receiver

Hardwire within your system, including:
- developing standardized forms, tools and methods, such as checklists
- using a quiet workspace or setting that is conducive to sharing information about a patient
- stating expectations about how to conduct a successful hand-off
- identifying new and existing technologies to assist in making the hand-off successful

Allow opportunities to ask questions, including:
- using critical thinking skills when discussing a patient's case
- sharing and receiving information as an interdisciplinary team (e.g., a pit crew)
- expecting to receive all key information about the patient from the sender
- exchanging contact information in the event there are any additional questions
- scrutinizing and questioning the data

Reinforce quality and measurement, including:
- demonstrating leadership commitment to successful hand-offs
- holding staff accountable for managing a patient's care
- monitoring compliance with use of standardized forms, tools and methods for hand-offs
- using data to determine a systematic approach for improvement

Educate and coach, including:
- teaching staff what constitutes a successful hand-off
- standardizing training on how to conduct a hand-off
- providing real-time performance feedback to staff
- making successful hand-offs an organization priority

Hand-off Communications collaborating hospitals
Exempla Lutheran Medical Center, Colorado
Fairview Health Services, Minnesota
Intermountain Healthcare LDS Hospital, Utah
Kaiser Permanente Sunnyside Medical Center, Oregon
Mayo Clinic Saint Marys Hospital, Minnesota
New York-Presbyterian Hospital, New York
North Shore-LIJ Health System Steven and Alexandra Cohen Children's Medical Center, New York
Partners HealthCare, Massachusetts General Hospital, Massachusetts
Stanford Hospital & Clinics, California
The Johns Hopkins Hospital, Maryland

For more information about this project, its solutions and the project team, visit the project detail page, or the Center website.