CASE REPORT

# The Development of a Daily Comprehensive and Multidisciplinary Health Care Leadership Huddle

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## ABSTRACT

**Introduction:** Consistent and concise communication in a large health care organization that is geographically dispersed is a challenge. Issues often are not addressed with the appropriate individuals in the most timely and effective manner, which results in patient flow disruptions, service gaps, and provider and administrator frustration.

**Case Presentation:** This report describes the development of a daily leadership huddle with regional leadership and middle management to inform of daily operations, safety, quality, and service concerns, in order to allow for quicker action and issue resolution.

**Discussion:** Huddles have proven effective in organizations of similar size, but few organizations have attempted a multisite daily huddle.

**Conclusion:** To ensure their success, key steps must be taken during the formation of daily leadership huddles, including buy-in from leaders and stakeholders at multiple levels. In our organization, the huddles have proven to be a forum for effective communication, quicker issue resolution, and an increased sense of camaraderie.

## BACKGROUND

Many health care systems have grown larger, more complex, and increasingly matrixed in the past few decades. While larger systems have the advantage of additional resources, they typically struggle with daily system-wide operational awareness and communication.

Mayo Clinic Health System Northwest Wisconsin Region operates in a hub-and-spoke model with one Level II trauma center, 4 critical access hospitals, and 14 ambulatory multispecialty clinics spread across 80 miles. The hospital operations and ambulatory clinic operations typically have not interfaced daily, although their issues are often intertwined. The organization has lacked a forum for managers to report—and senior leaders to become aware of—issues occurring throughout the system during daily operations in patient care areas, which creates a barrier to their timely resolution. Updates from all the different units, departments, and locations would require multiple communications and a significant time commitment from leadership.

The primary objective of this project was to develop a daily huddle with regional leadership and middle management to inform daily operations and safety, quality, and service concerns, thereby allowing for quicker action and issue resolution.

## METHODS

### Literature Review

A literature review was conducted to find best practices for huddling and communication in health care organizations. Increasing evidence has shown that organizations conducting high-risk activities, such as health care organizations, have better outcomes and situational awareness if daily multidisciplinary huddles are utilized.[1-4] High-reliability organizations consider huddles a mechanism to allow for increased trust by discussing situations caregivers encounter daily and understanding the reasons for errors.[5] The Institute of Healthcare Innovation encourages health care organizations to use daily huddles as a tool to promote a culture of safety and to sustain quality improvement.[6]

There are many best practices for running a successful hud-

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dle, beginning with establishing the routine, involving the right people, and having a consistent time and meeting location.[7]

Huddles can be as brief as 5 minutes and should be no longer than 15 minutes.[7] Other best practices include developing relationships, establishing the daily leader, using a standard template or script,[7] and establishing a "meeting-free zone" (a dedicated time with no meetings) to allow for daily rounding with front-line staff to share pressure points.[1]

Goals for huddling include removing barriers, improving communication, and enhancing collegiality, as all huddle members should be recognized as integral to success.[8] For huddles to meet their purpose, feedback should be solicited from attendees; and huddles should constantly be improved.[7]

### Huddle Formulation

Before developing a new huddle process, we canvassed our organization to find already-established huddles. Many departments had department-specific or team-specific huddles in place, including an inpatient bed management huddle that has been in place for many years and is scheduled every day from 8:15 AM to 8:30 AM. Nursing unit representatives from each site huddle to discuss bed placement, staffing, patient acuities, and surgical patient placement, along with other patient flow issues. Thus, a natural time to schedule the new daily leadership huddle was immediately following this huddle.

A key to implementing and maintaining successful huddles is achieving buy-in from organizational leaders.[3,8,9] Senior leaders should be able to articulate the purpose of a daily huddle, the value of daily reports, and interact with department representatives. In this case, the concept for the daily leadership huddles was presented and agreed upon by multiple clinical practice and senior leader committees.

Formulating the huddle structure was challenging given the involvement of 5 integrated hospitals and multiple ambulatory clinics spanning 80 miles. We determined it was critical to identify a senior leader champion to be active in the huddle formulation and, once implemented, to attend the huddles each day. This champion also assisted in gaining critical buy-in from the other senior and department leaders who provide daily reports.

Most of the reporters identified hold management-level positions within their departments; some have responsibility over multiple departments. Multiple meetings were held with stakeholders to understand their workflow and how implementing the huddles would affect their daily routines. The intent was to create a process that would not impact major workflows or create hours of prework prior to each huddle. Reporters were asked to formulate a process in which their department's employees could inform them of issues experienced in the previous 24 hours and those expected in the next 24 hours. Some reporters were asked to report for their departments as a region, which required developing different processes for gathering information.

Throughout the development process, it was imperative to demonstrate how the daily huddles would benefit the reporters and their work areas. For example, issues raised by departments may affect other departments, and the huddles would allow managers to inform and prepare their work units for potential issues. Reporters could expect senior leaders to provide resources to assist in resolving issues more quickly than experienced previously. In addition, a variety of nonreporters representing different non-patient care support services also would be attending the huddles and would be able to assist in resolving issues facing the organization.

A major challenge during the huddle formulation phase was incorporating both inpatient and outpatient department reports. While the inpatient reporting structure was straightforward since each department and critical access hospital would be designated to provide a report, reporting for outpatient service lines posed a greater challenge. Outpatient services were consolidated into a primary care report and a medical specialty report. Designated reporters were required to develop processes to receive information each morning on issues facing the multiple specialties within their reporting purview and consolidate it into a single report that focuses on daily fill rates, appointment availability, and provider absences affecting access and other safety, quality, service, and operational issues.

### Huddle Format and Pilot

The multidisciplinary daily huddles were launched as a pilot project on January 2, 2018, with a weekly rotation of the administrator-on-call leading the huddles. There was a rotation of 7 administrators-on-call at the onset of the pilot, and each huddle ran in similar fashion regardless of the leader.

Huddles were scheduled for 15 minutes and occurred each weekday from 8:30 AM to 8:45 AM. The average length was 7 to 10 minutes but could last the full 15 minutes if the day was particularly busy. A call-in number was utilized to provide greater flexibility and allow for participation from regional site representatives.

Reporters and the administrator-on-call leader were provided a script to formulate their reports, and all reporters were expected to provide a report even if their areas had no items to bring forward that day. The script was an essential component of the huddles as it ensured attendees were kept on task, and that the reports were provided in a similar format by each reporter. (See Box 1 for script.) At the conclusion of each huddle, the administrator-on-call leader requested live feedback for improvements.

After the first 2 weeks, the huddles became an integral part of the daily routine and continue today with the same format. There were 17 reporting departments during the huddle pilot, as well as numerous non-reporting department representatives from a variety of support services, for a total of 25 daily attendees. Since then, the number of attendees has grown to over 40 and includes those who participate via phone and the non-

reporting members. Ten senior leaders and a combination of 30 nursing and administrative frontline managers regularly attend. Reporters and huddle leaders are required to designate a backup reporter in the event they are unable to attend. And, as part of a physician-led organization, 4 regular physician leaders also participate, including the regional chief executive officer. Reporting departments are listed in Box 2.

An action log is kept detailing any significant issues raised that require additional follow-up, and a brief status report is expected at subsequent huddles until the issue is resolved. Each action log item is assigned to a specific individual who is responsible for the item until its resolution. As a result, those who are responsible for the item tend to work quickly to resolve the issues so it doesn't linger on the action log.

In addition to operational, quality, safety, or service issues that have been experienced in the past 24 hours, reporters also are asked to report any potential issues anticipated in the next 24 hours. Examples of items discussed include staffing shortages, weather-related concerns, hospital bed status, critical equipment downtime, security concerns leaders should be aware of, expected admissions and discharges, and outpatient access by specialty. Metrics on days since last serious harm event, last retained surgical instrument, and diversions (acute care, intensive care, psychiatry, and emergency department) are also reported, as well as additional patient safety metrics, such as near misses and root cause analyses.

Some items discussed affect the entire institution, while others are isolated to the inpatient or outpatient practices. As the huddles continue to evolve, participants learn more about anticipating issues and preventing problems before they start, based on information provided by other areas. Ultimately, managers and leaders are made aware of potential issues that may impact their work units each day.

The leadership huddles have built upon the individual work unit huddles, which almost all inpatient and outpatient care teams were already engaging in on a daily basis. There is no one way of conducting the care team huddles, but many involve status updates on patient conditions and counts, goals for the day, and other information staff members should know. Information shared at the daily leadership huddles is often collected from the work unit huddles, and some relevant information is pushed back to the work units after the leadership huddle. It is a the managers' responsibility to share relevant information with their work units.

## RESULTS

The implementation of daily leadership huddles has allowed communication to flow more easily across all sites in the region, which, in turn, has also allowed senior leadership to become more engaged and aware of daily operational, quality, safety and service concerns. The huddles have proven to be an effective forum for resolving issues affecting patient care areas, and the non-reporting attendees representing support services are often able to assist in resolving these issues.

A web-based internal survey tool was used to collect data on the attendees' perceptions of their satisfaction, awareness, and abilities before and after the huddle implementation. Surveys were categorized and sent to 3 distinct groups of individuals—senior leaders, reporters, and non-reporters—and included specific questions tailored for each group. The survey consisted of several questions that the respondents answered using a Likert scale of 1 to 5.

Responses to all questions across all 3 groups surveyed showed improvement in each category after huddle implementation. The senior leader survey revealed large improvements, in particular with their awareness of daily operational concerns and hospital

**Box 1.** Script for Daily Leadership Huddle

The script reads as follows:

1. Leader: "Good morning, welcome to the daily leadership huddle. Our purpose for the daily leadership huddle is to
    1. Look back on any actual significant safety, quality, or service issues from the past 24 hours
    2. Look ahead to anticipate and plan for any potential issues that may occur within the next 24 hours, and to
    3. Follow up on issues identified on previous days and what action items are in place to resolve them
- Attendees are encouraged to share open and honest information about the units/departments they represent. Please refrain from using specific patient identifiers.
- The days since the last serious harm event has been _____
- I will start with my Admin-on-call report."

2. Reporter:
    1. "This is <Name> reporting for <Department>. In the last 24 hours, we have had the following issues: <List issues>.
        a. We have done <Actions> to address them.
        b. In the next 24 hours, we anticipate that ________ might cause quality, safety, or service issues. We need and/or plan to do <action by your department or another> to prevent issues.
        c. I <do or do not> need assistance on this issue. This concludes my report.

        -Or-
    2. "This is <Name> reporting for <department>. We have no issues to report."

**Box 2.** Daily Leadership Huddle Reporting Departments

1. Administrator-on-call
2. Regional Bed Meeting Summary
3. Medical/Telemetry unit
4. Medical/Surgical unit
5. Neuro/Pediatrics/Trauma Unit
6. Critical Care Unit
7. Emergency Department
8. Inpatient Behavioral Health
9. Critical Access Hospital 1 & 2
10. Critical Access Hospital 3
11. Critical Access Hospital 4
12. Radiology
13. Pharmacy
14. Procedural Areas
15. Outpatient Medical Specialties
16. Outpatient Primary Care
17. Information Technology
18. Home Health and Hospice
19. Chief Medical Officer Report

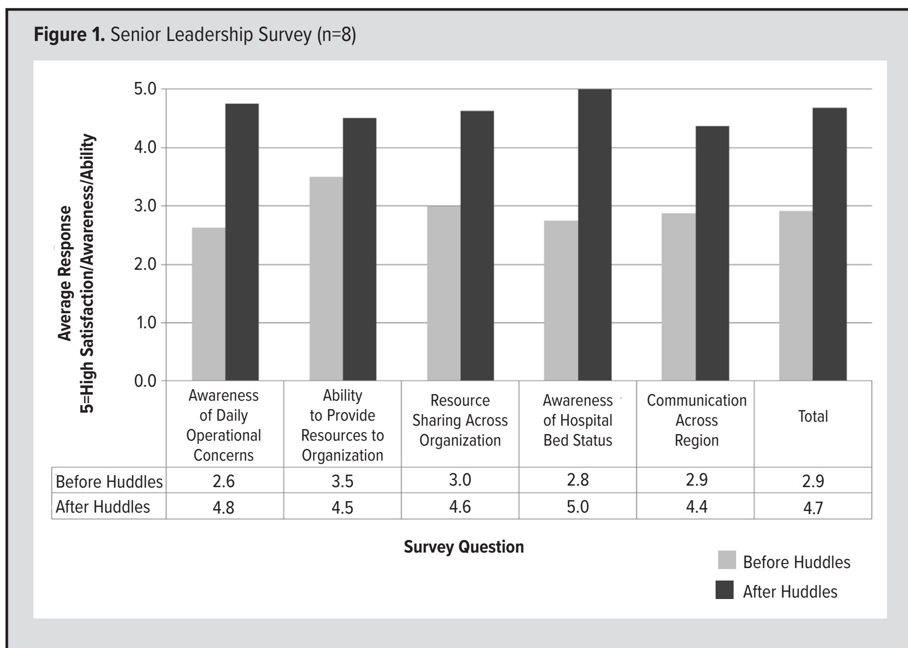


**Figure 1.** Senior Leadership Survey (n=8)

bed status. In this group, perceptions of communication across the region improved 52%, and improvement over all questions surveyed was 62% (Figure 1).

The reporting department representative survey showed major improvements in the perception of senior leader awareness of daily operations and interdepartmental communication after huddle implementation. The reporting departments identified less improvement in these areas (50% improvement in communication and 59% improvement overall), likely due to the solid communication procedures already existing within each department (Figure 2).

Categories showing the largest improvement in the non-reporting department representative survey included interdepartmental issue awareness, timeliness of being made aware of issues, and their perception of senior leader awareness in operational issues. Following huddle implementation, the non-reporting departments showed a 76% improvement in communication across the region and a 73% improvement across all categories surveyed (Figure 3).

Interviews were conducted with 15 huddle attendees, including senior leaders, reporters, and non-reporters, to gain their perspectives on the impact of the daily leadership huddles. The organization's regional chief executive officer said one of the biggest huddle benefits is the newfound ability to know by 8:45 AM each day if there are any major hotspots in the region and plans in place to address those issues. He recalled an incident when a staff surgeon called him at 6 AM to inform him of a critical patient flow issue, and he said it was a great assurance to know that the issue would be discussed with the appropriate stakeholders at the daily huddle. A plan to resolve this issue was made by 8:45 AM with minimal impact to patient flow.

The regional chief administrative officer said he considered the huddle the most important meeting of the day. The active engagement of all participants and visibility of senior leaders at the huddles are the factors most important to the huddles' success. He emphasized that the huddles provide a much clearer picture of the organization's daily state, specifically inpatient and outpatient practices and bed management, and gives rise to potential issues that can be prevented or mitigated.

The regional chief nursing officer noted that the daily huddles have given nursing leaders a forum to highlight challenges that previously may not have been shared and discussed. They have provided more momentum to several key organizational issues, including workplace safety and staffing management. She acknowledged that the region now functions better as a system through enhanced teamwork and an improved shared understanding of other departments.

The daily leadership huddles have continued to highlight the difficult scenarios caregivers face and, as a result, projects have been launched to keep staff as safe and efficient as possible. Instituting the huddles has allowed the organization to shift from a historical reactive strategy regarding patient safety issues to finding potential issues proactively and shifting resources to solve issues when needed. The huddles have also created a sense of increased cohesiveness and feelings of working together as a team across specialties and professions within the organization. By listening to what is happening in the patient care areas every day, non-patient care/supporting departments have indicated feeling less isolated and able to better understand how their decisions and work effect the rest of the organization. These departments, including patient experience, public affairs, patient safety, facilities, and information technology, have all highlighted issue transparency, an increased sense of belonging to a greater purpose, and improved teamwork across the region as benefits of the huddles.

The daily leadership huddles have also proven to be an ideal forum in which issues can be raised and resolved in a short amount of time. Four months after the implementation of the huddles, 94 significant issues had been identified and resolved. Examples include absence of call coverage for obstetrics at a critical access hospital, moisture in operating rooms due to ventilation issues, and critical pharmaceutical shortages. During the same time period, 28 greater systemic issues were identified and have been tasked to committees for resolution. These larger, complex issue call for practice or organizational changes and require investigation, discussion, and planning.

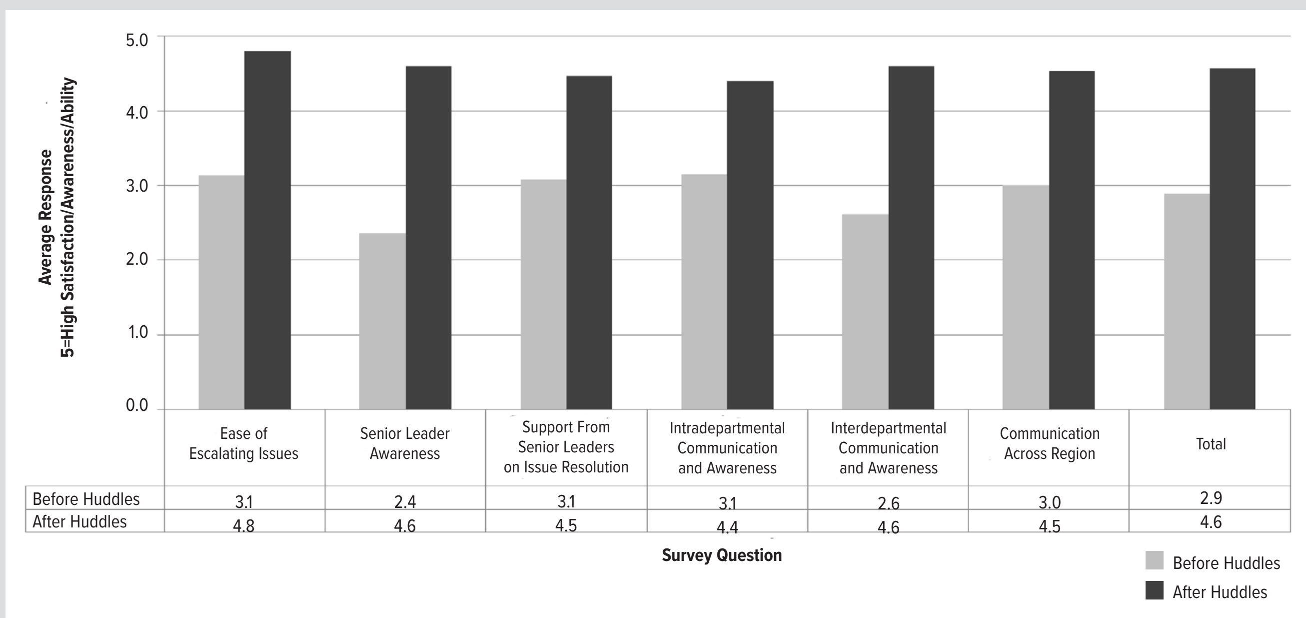


Figure 2. Reporting Department Survey (n=15)

| | Ease of Escalating Issues | Senior Leader Awareness | Support From Senior Leaders on Issue Resolution | Intradepartmental Communication and Awareness | Interdepartmental Communication and Awareness | Communication Across Region | Total |
|---|---|---|---|---|---|---|---|
| Before Huddles | 3.1 | 2.4 | 3.1 | 3.1 | 2.6 | 3.0 | 2.9 |
| After Huddles | 4.8 | 4.6 | 4.5 | 4.4 | 4.6 | 4.5 | 4.6 |

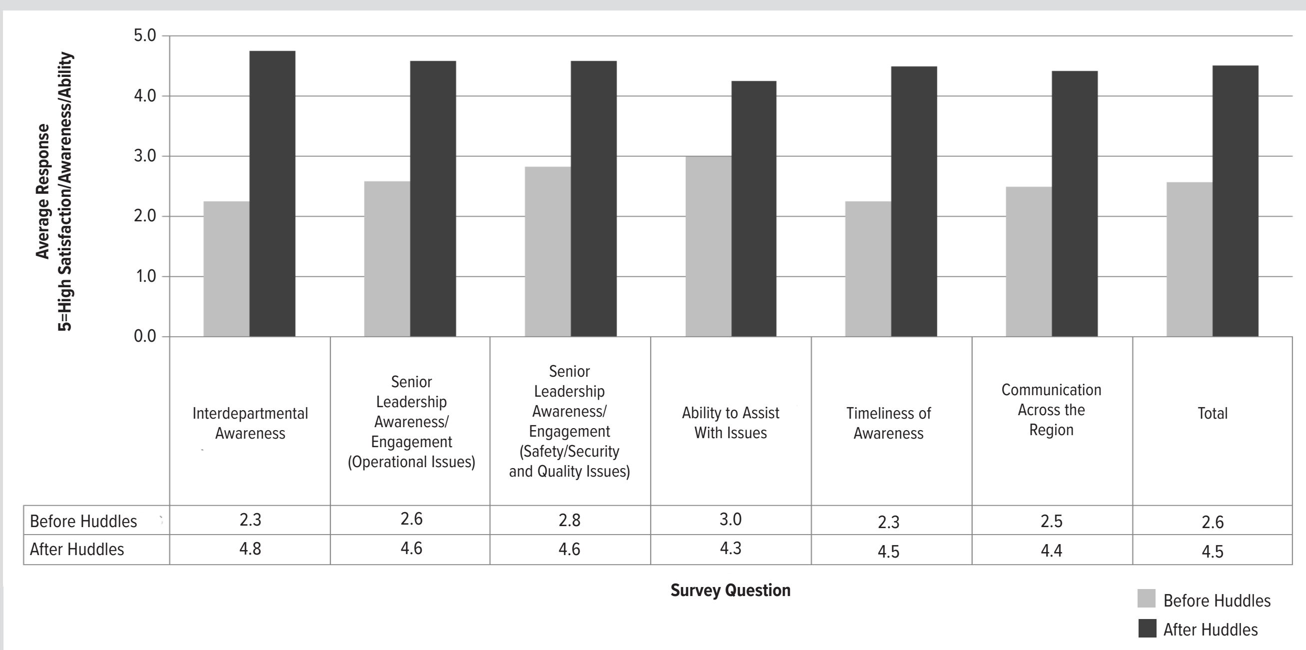


Figure 3. Non-Reporting Department Survey (n=12)

| | Interdepartmental Awareness | Senior Leadership Awareness/ Engagement (Operational Issues) | Senior Leadership Awareness/ Engagement (Safety/Security and Quality Issues) | Ability to Assist With Issues | Timeliness of Awareness | Communication Across the Region | Total |
|---|---|---|---|---|---|---|---|
| Before Huddles | 2.3 | 2.6 | 2.8 | 3.0 | 2.3 | 2.5 | 2.6 |
| After Huddles | 4.8 | 4.6 | 4.6 | 4.3 | 4.5 | 4.4 | 4.5 |

## Limitations

The outpatient and inpatient areas have different structures in place. As discussed, the designation of a report for outpatient practices proved to be difficult. Each outpatient specialty is managed by a different individual, yet we did not want a report from each specialty as the huddle would become quite long. While we settled on a report from medical specialties and a primary care report, the structure is still not ideal. Not all relevant information can be included in each huddle due to the vastness of the specialties, and the ability to gather a relevant update by 8:30 AM can be challenging for reporters.

Senior leaders must be champions of the leadership huddle, otherwise, it will not add value to anyone's day. The beauty of the leadership huddle is the leaders' engagement in operational activities and the front-line managers' interface with problem-solving among the high-level leaders. Developing and sustaining a daily

leadership huddle takes a lot of work and effort. Leaders who are uninterested in the discussion and content will diminish the value of the huddle. It is of the utmost importance that leaders attend and actively participate every day.

## DISCUSSION/CONCLUSION

While the concept of a daily 15-minute huddle seems straightforward, developing and coordinating this type of huddle in a large, complex, and geographically dispersed health care organization is very challenging. With commitment of leadership and operational management at all levels, we were able to successfully launch regional daily leadership huddles with widespread support and success. The huddles have now become an accepted and instrumental practice in the region.

Consistent with our system's culture of continuous improvement, we have continued to review the efficiency and effectiveness of the huddles post-implementation. One notable improvement is the review and addition of new reporting departments. An information technology report has been added, which has been deemed immensely helpful as the entire health care system, which spans several states, goes live with a new electronic health record (EHR). Unplanned EHR downtimes, changes to the EHR format, and issues experienced by departments using the EHR have all been reported in the daily leadership huddles. It is likely that without this daily forum, an array of emergency meetings and communication would have been needed to address many of the unplanned EHR issues.

Another improvement to the huddles was the identification of credible and meaningful metrics for the outpatient primary care and medical specialty groups to report on. In addition to the safety metrics reported out daily, the outpatient practices also report fill rates and specialties with the greatest or least amount of daily patient access. We have included temporary reports for seasonal issues, including an influenza report during peak flu season, and the huddles have also provided a positive forum for outstanding team and award recognitions.

The comprehensiveness of the huddles has allowed inpatient and outpatient services to be more synchronous, and the non-patient care departments have gained a better understanding of daily concerns facing patient care areas. Senior leaders have been able to articulate the exact activities and areas of concerns the entire region experiences on a daily basis.

Overall, the major benefits of the daily leadership huddles include improved communication, better coordination of resources, improved awareness of daily operations, swifter issue resolution, and a greater sense of collegiality across the region.

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## REFERENCES

**1.** Sikka R, Kovich K, Sacks L. How every hospital should start the day. Harvard Business Review. Published December 5, 2014. Accessed June 11, 2018. https://hbr.org/2014/12/how-every-hospital-should-start-the-day

**2.** McBeth CL, Durbin-Johnson B, Siegel EO. Interprofessional huddle: one children's hospital's approach to improving patient flow. *Pediatr Nurs*. 2017;43(2):71-76.

**3.** Glymph DC, Olenick M, Barbera S, Brown EL, Prestianni L, Miller C. Healthcare Utilizing Deliberate Discussion Linking Events (HUDDLE): a systematic review. *AANA J.* 2015;83(3):183-188. https://www.aana.com/docs/default-source/aana-journal-web-documents-1/healthcare-utilizing-0615-pp183-188.pdf?sfvrsn=45d448b1_6

**4.** Townsend CS, McNulty M, Grillo-Peck A. Implementing huddles improves care coordination in an academic health center. *Prof Case Manag.* 2017;22(1):29-35. doi:10.1097/NCM.0000000000000200

**5.** Dutka P. The huddle: it's not just for football anymore. *Nephrol Nurs J.* 2016;43(2):161-162.

**6.** Huddles. Institute for Healthcare Improvement. Published 2018. Accessed June 13, 2018. http://www.ihi.org/resources/Pages/Tools/Huddles.aspx

**7.** Yu E. Daily team huddles boost practice productivity and team morale. American Medical Association. Published October 7, 2015. Accessed June 11, 2018. https://edhub.ama-assn.org/steps-forward/module/2702506

**8.** Cooper RL, Meara ME. The organizational huddle process--optimum results through collaboration. *Health Care Manag (Frederick).* 2002;21(2):12-16. doi:10.1097/00126450-200212000-00003

**9.** Provost SM, Lanham HJ, Leykum LK, McDaniel RR Jr, Pugh J. Health care huddles: managing complexity to achieve high reliability. *Health Care Manage Rev.* 2015;40(1):2-12. doi:10.1097/HMR.0000000000000009

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