The concept of a “huddle,” a brief meeting between physicians and support staff prior to patient care sessions, has been advocated by the Institute for Healthcare Improvement as a tool to enhance communication, teamwork, efficiency, and patient safety. The practice management literature offers much guidance regarding implementing office huddles in established physician practices. In contrast, the medical education literature has little discussion regarding huddles in residency education. As we prepare residents to practice in patient-centered medical homes, we must train them to be effective team members and leaders, as required by the Accreditation Council for Graduate Medical Education (ACGME) core competencies. Participating in office huddles is a practical way for residents to learn these skills under faculty supervision.

Methods
Implementation
After a 6-month multidisciplinary planning process, we implemented huddles prior to each office session in our residency’s Family Medicine Center (FMC). FMC sessions are staffed with four to six residents, one to three faculty, and nursing and clerical personnel. Since our practice is divided into two teams, we started with two separate huddles, each attended by faculty and residents seeing patients, the preceptor, and a nursing and clerical staff representative from each team. A huddle script including the content and process for conducting the huddle was also developed.

Initially, faculty led the huddles to teach and role model the process. Within a few weeks, leadership transitioned to senior residents. Huddle leaders first asked each physician to identify special needs for his/her patients, eg, having a diabetic patient remove shoes and socks, giving a glucose to a pregnant patient on arrival at the reception desk, and identifying patients at risk for falling or those who may need interpreter services. The leader then asked the nurse to review the list of same-day “sick” patients, enabling participants to contribute additional information they may know about them. The nurse also reviewed staffing and equipment/supply issues, such as flu shot availability. The clerical representative then announced cancellations or other issues that could affect patient flow, such as absent staff or computer problems.

Based on feedback after the first few weeks of implementation, the two team huddles were combined. With only six to seven physicians seeing patients, one huddle allowed more effective communication among providers and staff. The nursing and clerical representatives were reduced to one each, which helped our limited staffing and the need for others to attend to patient care duties. Those representatives became responsible for sharing information with the rest of the staff.

Additional problems addressed within the first few weeks included huddles not starting on time, the reluctance of some individuals to speak in the group, and inadequate preparation that lengthened the huddle’s duration and diminished its patient care effectiveness. Solutions implemented included overhead announcements of the start of huddles and changing the order of speakers with the clerical representative speaking first, followed by nursing, and then physicians. A senior resident assigned to see mostly same-day sick patients became huddle leader and responsible for reviewing the list of sick patients. This assignment rotated evenly among senior residents and ensured equal exposure to the leadership role. Physicians learned to prepare by taking 5 to 10 minutes to review their charts in advance. These changes, implemented within the first 2 months, ultimately led to huddles with well-prepared physicians starting promptly and lasting 2 to 8 minutes. This huddle format remains unchanged.

Evaluation
In October 2008 and March 2011, 6 months and 3 years respectively after implementing huddles, we conducted surveys that asked all huddle participants if they agreed, disagreed, or were unsure about seven statements (Table 1) and invited additional comments. The seventh

From the JFK Family Medicine Residency Program, Edison, NJ.
For the majority of residents, huddles improve patient safety, facilitate good patient care, and improve patient continuity (Table 1). Of note, despite the huddles taking additional time, a solid majority of survey respondents (79% in 2008 and 84% in 2011) felt they were worth the effort (Table 1). Six months after huddle implantation, not a single respondent answered that huddles made his/her job harder.

**Faculty Interviews**

The faculty was unanimous in its belief that huddles provide our residents with a new platform to demonstrate and continually improve their skills in communication, teamwork, and team leadership (Table 3). A majority believed that huddles educate residents in the power of the interdisciplinary team to enhance patient safety and improve overall patient care. Several faculty also noted that by participating in huddles, residents gain practical skills in pre-visit planning and a more global understanding of practice logistics. More importantly, faculty found that observations of residents in huddles provided valuable insight into the residents’ skills in the ACGME core competencies of patient care, interpersonal and communication skills, professionalism, and systems-based practice (Table 3).

**Discussion**

While there is little discussion of office huddles in the graduate medical education literature, the practice management literature contains many descriptions of huddle benefits. Benefits experienced during our study are consistent with those reports. The effects of huddles were
Table 2: Representative Comments From Huddle Survey, by Respondent Category

<table>
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<tr>
<th>Category</th>
<th>Comments</th>
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| Residents   | “I find huddles a great way of communicating important information to nursing staff, front desk, and even the primary medical doctor (giving and receiving information). It not only has improved office flow, but overall care… “at risk” patients can be identified. Example, fall risk patients are identified.”  
“A great strength of FMC.”  
“Very good for the office. Even though sometimes the things mentioned in huddles are not carried out, patient flow is improved overall.” |
| Faculty     | “Have to work harder ahead of time to give appropriate information at huddle, but it does help with patient flow once hours start.”  
“Have definitely helped with communication between doctors and nursing; feels more like we’re all ‘on the same page.’”  
“In general the huddles have improved patient care and continuity.”  
“Residents have assumed more responsibility to maintain continuity of care since we started huddles. There is less complaining about seeing call-in patients…” |
| Nursing     | “Office huddles do not take long and provide very valuable communication between all staff members.”  
“Doctors need to take note of who the nurses are on their side so they don’t go to the nurse’s station every time they need something.”  
“Helps improve patient flow, continuity, and care…” |
| Clerical    | “I feel that the information given to us prior to the patient coming in helps our job at the front desk be more efficient.”  
“It does not affect me, but I feel it helps patients.”  
“I think huddles have improved the office flow.” |

Table 3: Faculty Interview Results: Educational Benefits of Huddles

<table>
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<tr>
<th>ACGME Competency</th>
<th>Instructional Opportunity</th>
<th>Evaluative Opportunity</th>
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<tbody>
<tr>
<td>Patient care</td>
<td>Faculty/senior residents model appropriate pre-visit planning</td>
<td>Faculty assesses residents’ patient management</td>
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</table>
| Interpersonal and communication skills | • Residents actively participate in interdisciplinary team  
• Observe value of all members’ roles  
• Faculty/senior residents model various leadership and communication styles  
• Practice role of huddle leader | Faculty observes:  
• Residents’ verbal communication with other participants  
• Residents’ leadership style/effectiveness |
| Professionalism  | Faculty/senior residents model interactional style that respects all participants          | • Faculty assesses residents’ punctuality  
• Faculty observes residents’ level of preparation  
• Faculty observes residents’ sense of patient ownership                              |
| Systems-based practice | • Learn to identify patients who are fall risks or have other special needs and communicate needs to all team members  
• Learn time-management strategies to maximize patient care by delegating non-physician care to other team members | Faculty observes:  
• Residents’ ability to work in interdisciplinary team to enhance patient safety  
• Residents’ awareness of patient needs (referral, transportation, translation) that improve patient care quality |
both immediate and enduring, making them a high-yield intervention that is well worth the effort. Additionally, huddles create educational and evaluative opportunities for residency programs. Our faculty now includes resident performance during huddles when completing summative evaluations of residents in the ACGME core competencies in Table 3.

The combination of faculty role-modeling, rotating senior residents’ leadership roles, residents’ desire to demonstrate competence and professionalism, overhead announcements, and the perceived benefits of huddles have led to timely huddle starts and consistent huddle preparation. In our office, the combined huddle structure proved to be more effective than the initial separate team structure and facilitates office flow and patient care. Potential areas for future research include studying the educational experience of other residencies that include studying the educational experience of other residencies that have implemented huddles, comparing them with those that haven’t, and assessing objective clinical measures before and after huddle implementation.

**Limitations**

The design of our study does not allow us to draw firm conclusions about the actual effects of huddles on patient safety, continuity of care, and office efficiency. Our findings are limited to the subjective opinions of study participants and reflect the experience of only one program. While our FMC is typical of a community hospital-based family medicine residency, our results may not translate directly to other FMCs.

**Conclusions**

It is likely that residents will be participating in and leading huddles in various practice settings after they graduate. To prepare residents for those roles, residency programs need to provide them with huddle experience. Our study suggests the huddle is a rich learning and evaluative opportunity for family medicine residency programs in addition to improving communication and facilitating office flow and patient care. Potential areas for future research include studying the educational experience of other residencies that have implemented huddles, comparing them with those that haven’t, and assessing objective clinical measures before and after huddle implementation.

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**Table 4: Questions Used in Structured Faculty Interviews Regarding Huddles**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
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<tbody>
<tr>
<td>1. Thinking about the FMC before and after implementation of huddles, what benefits/ drawbacks do you perceive for the practice? Explain.</td>
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<tr>
<td>2. (If not mentioned above) do you think huddles have improved:</td>
<td>a. Physician punctuality?</td>
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<td></td>
<td>b. Patient continuity with the same provider?</td>
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<td></td>
<td>c. Communication among team members?</td>
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<td></td>
<td>d. Office morale?</td>
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<td></td>
<td>e. Sense of patient ownership by residents?</td>
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<td></td>
<td>f. Sense of teamwork in FMC?</td>
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<td></td>
<td>g. Office efficiency?</td>
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<tr>
<td>3. What, if any, benefits do you think huddles have educationally for the residents? Explain.</td>
<td></td>
</tr>
<tr>
<td>4. Do you find huddles a useful opportunity to evaluate residents’ skills? If so, which skills/ competencies? Explain.</td>
<td></td>
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