Transitions of care occur each time the patient moves from one health care provider or health care setting to another. These care transitions are the highest risk phases of care for patients and may result in poor patient care and preventable readmissions. In fact, nearly one in five Medicare patients readmits to the hospital within 30 days (Jencks et al., 2009). Bi-directional communication and information transfer deficits during changes in facility level of care are common and may affect patient care.

At University of Wisconsin Hospital and Clinics, we determined that there were no standardized communication processes for transferring a patient to and from post-acute care facilities, i.e. skilled nursing and assisted living facilities. This had resulted in missed communications and a lack of pertinent clinical data necessary to care for the patient. As a result, a work group formed along with 4 skilled nursing and 3 assisted living facilities in the area to arrive at a consistent process to improve communication with handoffs. The processes are aimed to improve the quality of patient care at the time of the patient transfer, whether it is from a post-acute care facility to the emergency department or from the emergency department/inpatient unit back to a post-acute care facility.

While spending time understanding the current process, we developed a detailed process map of what was currently happening. Based upon our process map analysis we arrived at the need for a standardized transfer packet. Since June 2015 the blue transfer envelope process has been rolled out to the 7 pilot facilities, an additional 10 post-acute facilities (January 2016) and recently to the Skilled Nursing Facility Coalition members (May 2016).

**What was implemented?**

- Participating skilled nursing and assisted living facilities complete a standardized transfer label. The label includes important information for clinicians and the receiving facility such as: reason for transfer, level of care the resident is being transferred from, direct dial number, and other pertinent information (see example below).
- A standard blue 9x11” envelope is used to package the transfer documents; the completed handoff label is adhered to the outside of the envelope.
- Upon arrival to the UW Emergency Department, EMS transport staff hands the transfer packet to the Emergency Department Coordinator (EDC) for immediate scanning into the electronic medical record.
- An ED transitions checklist developed to standardize the process for patients returning to the post-acute care facility.
- An ED/Facility After Visit Summary created with additional clinical information the post-acute care facility requires such as ED vital signs, treatments, medication changes/additions.

**What is the goal?**
To improve the quality and safety of patient transfers.
To improve communication between facilities and EMS.
Implement standardized blue transfer envelope process to all post-acute care facilities

References