# Blue Transfer Envelope Process – Right Information Every Time
## *Improving Hospital and Facility Bi-Directional Communication*

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 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.

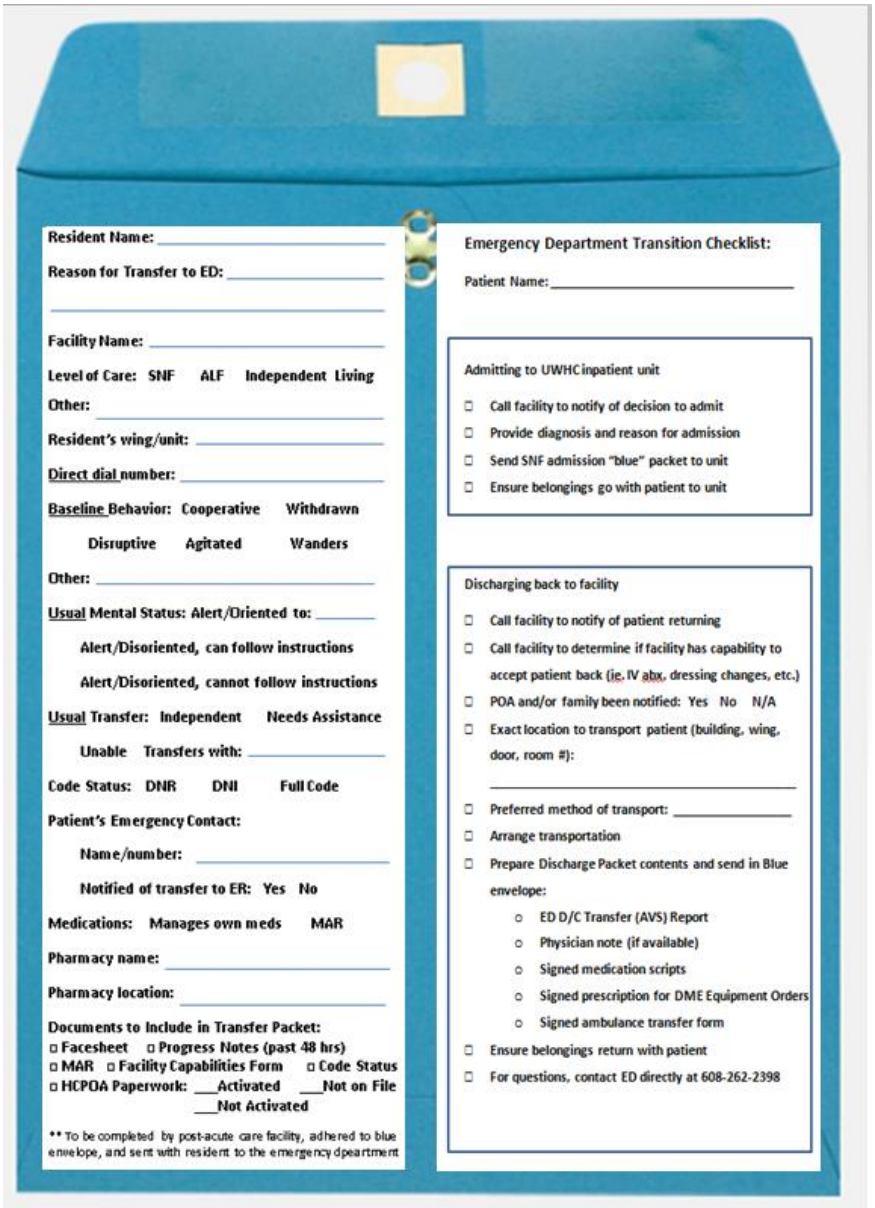
While spending time understanding the current process, we developed a detailed process map of what was currently happening. Based upon our process map analysis we arrived at the need for a standardized transfer packet. Since June 2015 the blue transfer envelope process has been rolled out to the 7 pilot 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



Resident Name: _____

Reason for Transfer to ED: _____

_____

Facility Name: _____

Level of Care: SNF ALF Independent Living

Other: _____

Resident's wing/unit: _____

Direct dial number: _____

Baseline Behavior: Cooperative Withdrawn

Disruptive Agitated Wanders

Other: _____

Usual Mental Status: Alert/Oriented to: _____

Alert/Disoriented, can follow instructions

Alert/Disoriented, cannot follow instructions

Usual Transfer: Independent Needs Assistance

Unable Transfers with: _____

Code Status: DNR DNI Full Code

Patient's Emergency Contact:

Name/number: _____

Notified of transfer to ER: Yes No

Medications: Manages own meds MAR

Pharmacy name: _____

Pharmacy location: _____

Documents to Include in Transfer Packet:
□ Facesheet □ Progress Notes (past 48 hrs)
□ MAR □ Facility Capabilities Form □ Code Status
□ HCPOA Paperwork: ___Activated ___Not on File
___Not Activated

** To be completed by post-acute care facility, adhered to blue envelope, and sent with resident to the emergency dpeartment

Emergency Department Transition Checklist:

Patient Name: _____

Admitting to UWHC inpatient unit

- □ Call facility to notify of decision to admit
- □ Provide diagnosis and reason for admission
- □ Send SNF admission "blue" packet to unit
- □ Ensure belongings go with patient to unit

Discharging back to facility

- □ Call facility to notify of patient returning
- □ Call facility to determine if facility has capability to accept patient back (ie. IV abx, dressing changes, etc.)
- □ POA and/or family been notified: Yes No N/A
- □ Exact location to transport patient (building, wing, door, room #):

  _____
- □ Preferred method of transport: _____
- □ Arrange transportation
- □ Prepare Discharge Packet contents and send in Blue envelope:
  - ED D/C Transfer (AVS) Report
  - Physician note (if available)
  - Signed medication scripts
  - Signed prescription for DME Equipment Orders
  - Signed ambulance transfer form
- □ Ensure belongings return with patient
- □ For questions, contact ED directly at 608-262-2398

**References**

Jencks, S., Williams, M., Coleman, E. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine,* 360(14), 1418-1428.