Project ECHO Care-Transitions Program Toolkit

Improving Safety of Transitions to Skilled Nursing Care Using Video-Conferencing Technology

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

About this Toolkit

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Toolkit Aims

The aims of this toolkit are to:

1. **Provide a blueprint for hospitals seeking to replicate the ECHO-Care Transitions Program**

2. **Allow others to learn from our experiences**

Glossary & Abbreviations

Glossary

ECHO Institute	Refers to Project ECHO's legal entity, faculty and staff as well as headquarters and physical location at UNMHSC in Albuquerque, NM
Hub	Regional center where multidisciplinary team of subject matter experts for a teleECHO program is located
Dry Run	A rehearsal that is scheduled prior to the teleECHO program launch where hub sites check VTC capability of the hub and spoke sites and to provide housekeeping information.
Spoke	Community partner site at which individual or team of learners is located and connects to hub via teleECHO sessions
ECHO ID	A number randomly assigned to each patient discussed in the ECHO-CT program

Abbreviations

ECHO-CT	Extension of Community Health Outcomes Care Transitions
BIDMC	Beth Israel Deaconess Medical Center
SNF	Skilled Nursing Facility
AHRQ	Agency for Healthcare Research and Quality
MOU	Memorandum of Understanding

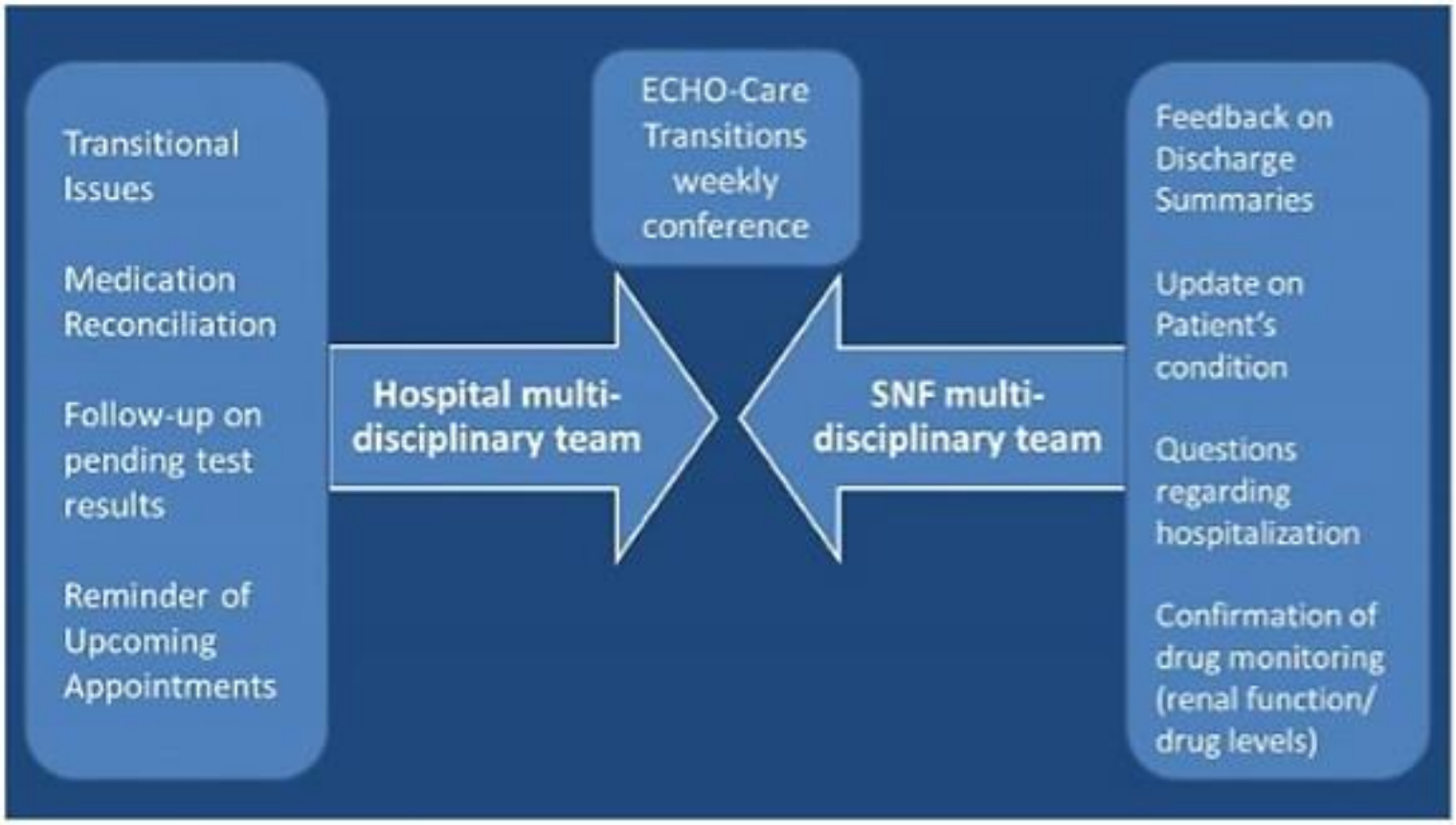
Program Overview

PROJECT ECHO-CARE TRANSITIONS: IMPROVING TRANSITIONS OF CARE

Beth Israel Deaconess Medical Center (BIDMC) developed ECHO-Care Transitions (ECHO-CT) to address gaps in care quality arising when a patient transitions from the inpatient hospital setting to a skilled nursing facility (SNF). The goal is to promote safe and effective transitions for complex older patients by improving communication between the hospital and the SNF providers. Within one week of discharge, hospital providers discuss each patient's transitional and medical issues with providers at the SNF using video-conferencing technology. The BIDMC and the SNF teams include physicians, nurse practitioners, nurses, pharmacists, and case managers. These multi-disciplinary teams allow for a discussion of a wide range of issues that affect patients transitioning to SNF care, including: medication reconciliation, critical laboratory/imaging results, discharge follow-up and case management issues. As part of the educational mission and a broader transitional care/geriatrics curriculum, internal medicine residents also intermittently lead the videoconferencing discussions. In a previous study published in the American Journal of Medicine this program reduced SNF length of stay, re-hospitalizations, and 30-day health care costs (Moore, 2017).

Building on previous research and with the support of a grant from the Agency for Healthcare Research and Quality, BIDMC launched a new research group of 17 SNF sites in April 2019. This new phase of the program includes an expansion of the ECHO-CT weekly sessions to include a hub at Beth Israel Needham. In partnership with Hebrew SeniorLife and Brown University, BIMDC seeks to determine if ECHO-CT can improve clinical outcomes and reduce cost and resource utilization during transitions of care in both an academic (BIDMC Boston) and community (BI Needham) hospital.

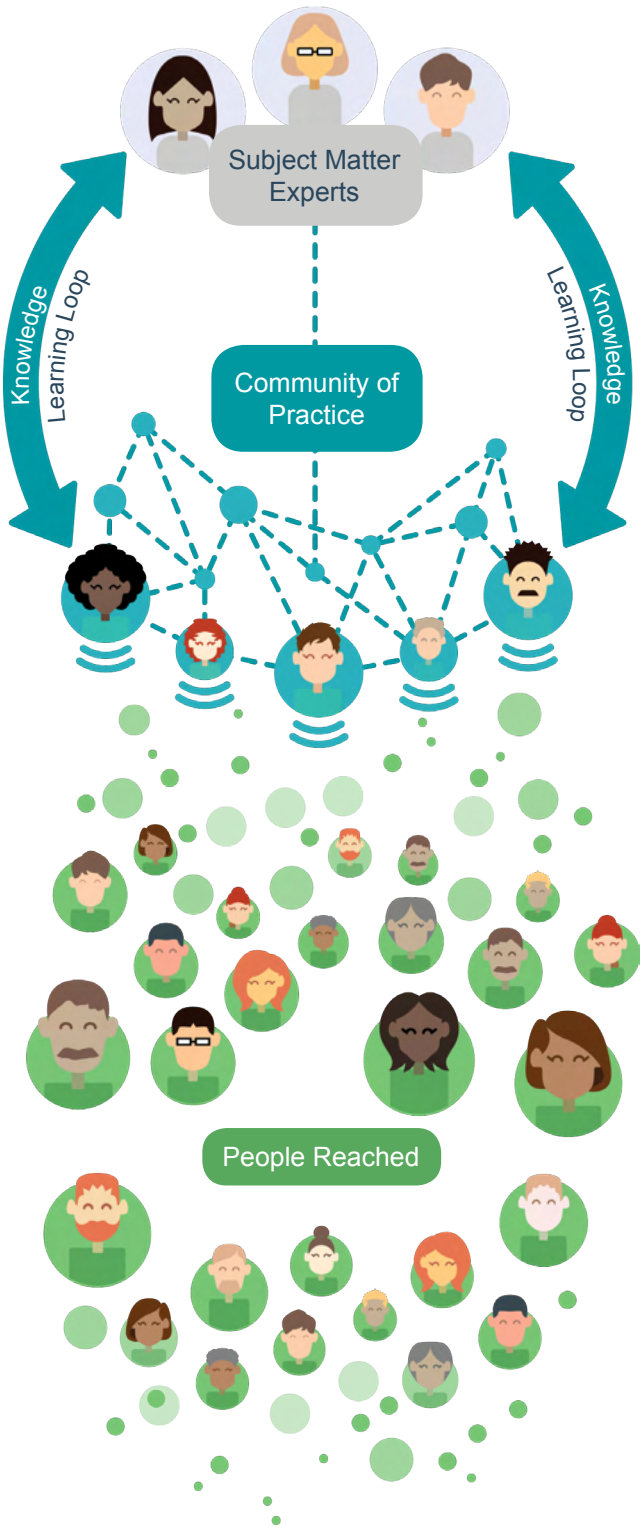
Program Overview



Moore AB, Krupp JE, Dufour AB, Sircar M, Travison TG, Abrams A, Farris G, Mattison MLP, Lipsitz LA. Improving Transitions to Postacute Care for Elderly Patients Using a Novel Video-Conferencing Program: ECHO-Care Transitions. Am J Med. 2017 10; 130(10):1199-1204.

Project ECHO®

The ECHO Model™



Moving Knowledge, Not People

Project ECHO (Extension for Community Healthcare Outcomes) is a movement to demonopolize knowledge and amplify the capacity to provide best practice care for underserved people all over the world. The ECHO model is committed to addressing the needs of the most vulnerable populations by equipping communities with the right knowledge, at the right place, at the right time.

Four Principles of the ECHO Model

- **Use Technology to leverage scarce resources**
- **Share "best practices" to reduce disparities**
- **Apply case-based learning to master complexity**
- **Evaluate and monitor outcomes**

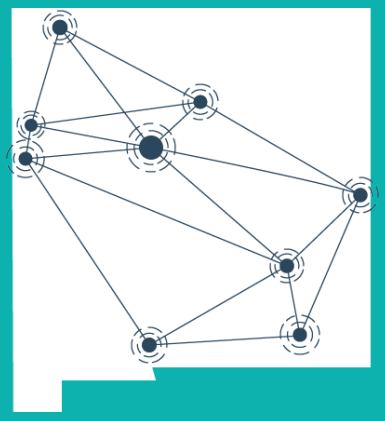
Benefits of Becoming a Part of the ECHO community

- Access Communities
- Reduce Disparities
- Promote Consistency
- Rapid Dissemination
- Increase Professional Knowledge
- Isolation Decrease

Are you part of ECHO?

For more information on Project ECHO visit: **echo.unm.edu**

Project ECHO®



Project ECHO's Story

Launched in 2003, Project ECHO grew out of one doctor's vision. Sanjeev Arora, M.D., a social innovator and liver disease specialist at the University of New Mexico Health Sciences Center in Albuquerque, was frustrated that he could serve only a fraction of the hepatitis C patients in the state. He wanted to serve as many patients with hepatitis C as possible, so he created a free, educational model and mentored community providers across New Mexico in how to treat the condition. A New England Journal of Medicine study found that hepatitis C care provided by Project ECHO trained community providers was as good as care provided by specialists at a university. The ECHO model is not traditional "telemedicine" where the specialist assumes care of the patient, but is instead telementoring, a guided practice model where the participating clinician retains responsibility for managing the patient.

Building a Global Community

Dozens of teleECHO™ programs addressing common complex conditions take place every week—and their reach extends far beyond New Mexico. Global interest is mounting. ECHO programs operate in North and South America, Europe, Australia, Africa and Asia.

Changing the World, Fast

Replicating the ECHO model across the U.S. dramatically increases the number of community partners participating in ECHO, enabling more people in rural and underserved communities to get the expertise they need.

215+
U.S. Partners

130+
Global Partners

38
Countries

Goal: Touch the lives of **1 Billion by 2025**

Are you part of ECHO?

For more information on Project ECHO visit: **echo.unm.edu**

Exporting the ECHO Model to BIDMC to Improve the Care of Older Adults

Drs. Lewis Lipsitz, Melissa Mattison and Stephen Gordon first learned about ECHO when they were introduced by a colleague to Dr. Sanjeev Aurora of the ECHO Institute at the University of New Mexico. After learning how Dr. Aurora had used ECHO to serve remote and under served populations struggling with Hepatitis C, they believed that the model could be helpful for providers in nursing homes, since many nursing homes are located in remote areas with under served residents.

To that end, in 2012 BIDMC started an ECHO program concerned with dementia care within skilled nursing facilities (SNFs). The program, called ECHO-AGE was funded by the Patrick and Catherine Weldon Donaghue Q1 Medical Research Foundation and Rx Foundation. ECHO-AGE ended in 2013 due to lack of continued funding.

The ECHO-Care Transitions (ECHO-CT) program began at BIDMC in 2013. This was the nation's first ECHO that focused on improving the transition from hospital to SNFs. The SNFs involved in the project are located throughout the Greater Boston area. The program is directed by Dr. Lipsitz. ECHO-CT was initially funded through the Reynolds Foundation which provided the program with a geriatric education grant. Not only did this phase of grant funding focus on care transitions between hospital and SNFs, it also focused on training and education for trainees and hospitalists in the issues surrounding transitions of care. This included a series of educational sessions and opportunities for trainees to lead the ECHO-CT sessions.

After the Reynolds Foundation funding ended, the program was briefly supported by the BIDMC Department of Medicine, while program leadership awaited word on numerous grant applications. Finally, in 2018, ECHO-Care Transitions was awarded a 3-year grant from the Agency for Healthcare Research and Quality (AHRQ). This federal grant allowed the program to expand to a community hospital, take on 17 new SNFs and recruit 800 patients to further examine the program's impact on SNF length of stay, readmission rates, cost per patient and adverse events.

Program Planning Timeline

- Create budget
- Secure funding
- Recruit hospital team
- Identify SNFs

- Submit IRB proposal (if applicable)
- Develop evaluation plan
- Recruit SNFs
- Create program processes & resources

- Train hospital & SNF staff
- Distribute program resources
- Acquire video-conference technology
- Conduct dry runs with technology

- Commence weekly sessions
- Collect data
- Conduct SNF staff satisfaction surveys
- Maintain program engagement

- Review & analyze data

ECHO-Care Transitions Program Toolkit Section 1

Program Overview & Planning

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Hospital Staff Recruitment

Recruitment Process:

1. Recruit staff from the following disciplines: hospital medicine, case management and pharmacy.
2. Speak with leaders in these areas to identify faculty and staff with demonstrated interest in quality improvement and strong leadership qualities.
3. Confirm with staff supervisors that faculty/staff can dedicate the needed amount of time to the project. Faculty/staff were provided with specific expectations of the role when asked to participate in the project.
4. Recruit a program manager/coordinator to coordinate the weekly sessions, collect medications lists, create case details and communicate with SNF participants.

Recruitment Recommendations:

1. Recruit 3-4 hospitalist facilitators. This allows for scheduling flexibility, even distribution of shifts between facilitators and decreased chance of session burnout.
2. The program manager/coordinator could be an external or internal recruit. A few important skills for this position include:
    - Detail oriented and organized
    - Experience in relationship building/management
    - Comfortable with technology/troubleshooting technology issues
    - Experience with quality improvement/process improvement

Funding & Budget Planning

Funding Sources:

- Funding can be obtained by grant support, hospital support, managed care insurers, accountable care organizations, philanthropy, and/or civil penalty funds.

Model Budget Overview:

***Salary includes FTE + fringe benefits, dependent on local salary levels**

ROLE	FTE	Salary
Program Director	10.00%	$24,902
Program Manager	50%	$41,665
Hospitalist Session Facilitator	3.50%	$7,702
Hospitalist Session Facilitator	3.50%	$7,702
Hospitalist Session Facilitator	3.50%	$7,702
BIDMC Pharm	7.00%	$10,770
Social worker	3.00%	$5,000
TOTAL		**$105,443**

Skilled Nursing Facility Identification

Identifying SNFs:

- Generate a report showing the frequency of discharges to each SNF that receives your patients.
- Possible consideration when choosing SNFs:
    - SNFs that receive too few discharges may not have enough patients to discuss every month.
    - SNFs that receive too many discharges may already have a strong relationship with the hospital and therefore may have less to gain by participating in the conference.

SNF Recruitment

Process:

Once SNFs are identified, SNF recruitment can begin:

1. Contact the executive director (ED) of each facility.
2. Send an email to the ED which briefly explains the program, benefits, and ask to schedule an in-person visit or phone call to discuss the program further.
3. Conduct an in-person visit or phone call with the ED and their team. During this meeting, goals, benefits, logistics & time-commitment should be discussed.
4. After SNFs agreed to join project, send a letter via email which outlines program expectations for the SNF teams. This is not a contract, memorandum of understanding (MOU) or other legal document. The ED should only be asked to affirm that they agree to the expectations outlined in the letter (sample in appendix).
5. Send a survey to the SNFs asking about logistics for conference scheduling (sample in appendix).
6. Ask SNFs to hold a date on their calendars for a half-day in-person orientation.

Hospital Staff & SNF Orientation

Purpose:

- The purpose of an in-person hospital and SNF staff orientation is to:
  - Introduce all participants and encourage networking
  - Encourage the formation of a learning community in which all participate and all learn
  - Explain importance of improving care transitions
  - Give overview of program and logistics

Planning Considerations:

- Session was a half-day orientation (4 hours total)
- Budget was $1500 which included: breakfast, parking, materials
- All hospital staff involved in the project were required to attend
- SNFs were asked to have two staff members attend: one clinical person, and one administrative person
- Name tags and ECHO session process guides were provided to each participant

Hospital Staff & SNF Orientation Cont.

Agenda items included:

- Introduction & icebreaker
- Transitions of care: scope of the problem (see appendix)
- ECHO-CT: past, present, future
- Video of an ECHO-CT session & discussion
- Logistics of ECHO-CT session & running an effective ECHO session
- Identifying common clinical problems encountered during care transitions

ECHO Care-Transitions Program Toolkit Section 2

Program Implementation

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Preparing for an ECHO-CT Session: Two Days Before Session

1. Generate list of patients that were discharged from the hospital that week to your ECHO-CT sites. Create agenda for session from this list of patients. Be sure to group patients in order by SNF presentation time.

2. Fill out the ECHO-CT data collection document. More information about what is included in this document can be found in section three of this toolkit.

   - Use the medical record number and/or last name to see if the patient already has an ECHO ID. If yes, add the current hospitalization below the patient's previous admission(s). If no, assign patients a new ECHO ID.
   - Email each SNF site separately the name of patient(s), DOB and ECHO ID. Attach an intake form to the email (see appendix) and confirm the time that their patients will be presented at the conference. Ask the SNF to fax the medication list to you. The sites should email you back to confirm that the patient is in their facility and the time.
   - Follow all confidentiality and security guidelines within your organization (i.e. send emails securely).

3. Send the draft list of patients with ECHO IDs and medical record numbers to the ECHO staff by 3pm two days before session.

Preparing for an ECHO-CT Session: One Day Before Session

1. Remind SNF to fax medication lists.

2. Collect and save any medication lists that the SNFs fax you.

3. The program coordinator should create a document containing clinical information for each patient the case details (sample in appendix). This document is given to the hospital team so that they have an overview of the patient's hospital course. For each patient, please include the following information obtained from the patient's medical record:
    - Brief overview of patient's hospital course (1-2 sentences)
    - Acute issues during hospitalization
    - Transitional issues
    - Follow-up needed or scheduled appointments

4. By 3pm, send the ECHO hospital team the case details, the medication list/intake forms, and the finalized agenda to review before the clinic.

Preparing for an ECHO-CT Session: Day of Session

Before the Session

1. Print and photocopy the agenda and the case details for the team and bring to the session.
2. Login to the videoconferencing platform a few minutes early to make sure it's working properly.

After the Session:

1. Update the data collection spreadsheet with information from the discussions.
2. Send a follow-up email to hospitalist on any follow-up action items needed.

ECHO-CT Roles Outline: Hospitalist Facilitator

Objectives:

- Lead an inter-professional discussion about a recently discharged patient.
- Identify any significant transitional issues and discuss these with SNF team.
- Avoid giving directions and instead give recommendations. Since you are not at the facility or providing direct patient care, it is hard to know all of the details and context of the patient's care.

Processes:

- Review the cases for any transitional issues that should be addressed during the session.
- The session is started with a brief description of the patient's hospital stay, the following script can be helpful:

"Pt #### is a 75 year old … with this, that and the other, admitted with xxx, discharged last week to complete an xxx course and improve his strength…..How is he doing?" Or "Are there any issues you would like to discuss?"

ECHO-CT Roles Outline: Hospital Pharmacist

Objectives:

- Identify any medication questions/discrepancies,interactions, contraindications, or allergies.
- Avoid giving directions and instead give recommendations. Since you are not at the facility or providing direct patient care, it is hard to know all of the details and context of the patient's care.

Process:

- Review home, inpatient/hospital, discharge and SNF medication lists. Note any questions or discrepancies.
- Medication reconciliation to review for correct medication, dose, frequency, formulation, route, duration, unintended medication additions or omissions, and duplicate therapy.
- Ensure medications are appropriately dosed for the patient's current renal function.
- During the conversation be sure to take note of any medication related topics and compare medication lists for errors/questions.
- Discuss medication-related monitoring for patients started on a new medication or medications that were adjusted during the hospitalization.
- Feel free to bring up any concern.

ECHO-CT Roles Outline: Case Manager

Objectives:

- Identify any patient barriers to safe SNF discharge i.e. fall safety, home supports.
- Assess whether there are any goals of care, and if not, coach the facility to obtain them.

Process:

- Review patient's inpatient course and discharge information.
- Discuss with group any potential concerns related to a safe discharge from the SNF.

ECHO-CT Role Outline: SNF Staff

Objectives:

- Update the hospital team on how the patient is doing and any issues/ questions regarding patient's current state.
- Discuss any transitions of care issues that occurred.

Process:

- Review the patient's inpatient course and discharge information.
- Review the patient's current medication list.
- Be prepared to discuss how the patient is currently doing and review any relevant clinical information (recommended to have patient's health record available) .
- Be sure to bring up any concerns regarding the transition of care.

ECHO-CT Session Process

1. **Facilitator:**
    a. Discusses patient using ECHO ID & not patient name or other identifying information
    b. Gives a brief summary of the case based on information from patient's notes
    c. Asks the facility how the patient is doing and if they have anything do add to the overview
    d. Addresses the following issues surrounding the transition, as appropriate to the patient being discussed, with the SNF team
    e. Reviews transition notes from discharge paperwork, often including but not limited to: staple removal, antibiotic course, INR check, labs
    f. Reviews scheduled appointments and appointments that need to be scheduled
    g. If the patient has any of the conditions listed in condition list (next page), follows recommendations listed
    h. Asks about anticipated date of discharge and any barriers to discharge
    i. Concludes the session by asking if there is anything that could have been improved during the patient's transition
2. **Pharmacist:**
    a. Reviews medications and provides input as related to medication reconciliation for each patient, if applicable
3. **Case Manager:**
    a. Identifies any issues surrounding the patient's home environment (if applicable)
    b. Inquires about the patient's goals of care (if applicable)
4. **All Team Members:**
    a. Help troubleshoot any problems with the rehab providers
    b. After the session, look up answers to lingering questions that could not be answered during the session and inform the SNF staff of the answers

Condition Checklist

Fractures

- ✓ Review medications that may contribute to falls and decreased bone mineral density
- ✓ Initiate appropriate medication management with Calcium and Vitamin D
- ✓ Calculate the FRAX score and provide a recommendation for a DEXA scan and/or initiation of a bisphosphonate

Falls/syncope

- ✓ Review medications that may contribute to sedation, hypotension, or impaired balance
- ✓ Monitor orthostatic vital signs
- ✓ Ensure home safety evaluation if plan for discharge home
- ✓ Encourage education around fall prevention

Altered Mental Status/Delirium

- ✓ Emphasize de-prescribing of medications that contribute to sedation or confusion
- ✓ Ensure workup for reversible causes of delirium has been completed
- ✓ Encourage non-pharmacologic management of delirium

Infection

- ✓ Encourage appropriate antibiotic stewardship (i.e recommended dose, duration, etc)
- ✓ Monitor for resolution or worsening of infection

Heart Failure

- ✓ Ensure appropriate monitoring of weight and volume status and encourage medication titration as indicated
- ✓ Review medication list with attention to inclusion of ACE-I and beta blockers, with discussion of contraindication if these medications are absent from the medication list
- ✓ Review indications for aspirin, statins, diuretics, etc.

SNF Educational Sessions

Twice yearly educational sessions were critical to fulfilling the educational mission of the program.
Topics include:

Frailty & Transitions of Care for Hospitalized Older Patients:

Objectives:

- Define frailty using commonly used frailty definitions
- Perform a brief screening test of frailty
- Interpret the results of a comprehensive geriatric assessment-based frailty index
- Develop a transition-of-care plan for medically complex older adults based on frailty assessment

Pitfalls of Pills

Objectives:

- Define adverse drug events (ADE) & their impacts
- Describe how ADEs relate to transitions of care
- Describe the common errors of ADEs
- List the common medications implicated in ADEs.
- Reflect on how we can prevent ADE through common case examples

SNF Educational Sessions Cont.

COVID-19 Session

Objectives:

- Define the prevalence of COVID-19 globally, nationally and locally
- Recognize the societal level impact of the pandemic
- Describe common complications of COVID in hospitalized patients
- List the current recommendations for management of patients with COVID
- Reflect on how we can mange patients post-discharge who were hospitalized with COVID

Continuous Program Quality Improvement

The ECHO-Care Transitions team used a number of program improvement processes and strategies:

Facilitator Feedback: Example scorecard in appendix

Each ECHO-CT facilitator was evaluated to ensure compliance with ECHO goals and consistency across sessions

- Occurred bi-annually
- Evaluated by program manager/coordinator
- Shared privately with facilitator after the session

SNF Satisfaction Surveys: Example questions in appendix

Each SNF was sent a satisfaction survey to access satisfaction and identify areas for improvement

- Occurred bi-annually
- Sent via secure survey service
- Shared with ECHO team & used for program improvements

Continuous Program Quality Improvement Cont.

Collection and Feedback of Care Transition Events

- During each ECHO-CT session, any clinical events were recorded and categorized by a session note-taker (see page # for more information). This data was used for research purposes and also for discharge process improvement.
- Critical care events that were uncovered should be shared with the appropriate department to foster improvement in the discharge or treatment process.

ECHO-Care Transitions Program Toolkit Section 3

Program Evaluation

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Data Collection Overview

- Data collection should be completed even if the program is not conducting research.
- Collecting data within a spreadsheet or other database is important for justifying the continuation of the program and collecting data on program metric to track progress.
- Programs should also collect data on the care transition events and patient safety issues that are detected during ECHO sessions.
- Keep databases password protected, back-up data often and keep the database inside their organization's firewall.
- Programs should use a database application that complies with HIPPA and the rules of their organization. Some possible suggestions include:
    - Microsoft Excel
    - Microsoft Access
    - Redcap

Data Collection

The ECHO data collection database includes the following data:

- Echo ID
- Patient name
- Date of birth
- Medical record number
- Gender
- ECF location where patient was discharged
- Admit date
- Discharge date
- Admitting diagnosis
- Name of patient's PCP
-

Information collected after each ECHO session:

- Was the patient presented at the conference (yes/no)
- Name of attending who saw patient while admitted
- Why patient was not presented at conference
- Date that patient was presented at conference
- Was a medical resident present (yes/no)
- Was the patient's inpatient team invited to the conference (yes/no)
- Was the patient's PCP invited to the conference (yes/no)
- Name of presenter at SNF site
- Whether phone or video was used during discussion of patient

Data Collection: Care Transition Events

During ECHO Conference, while each patient is discussed, a note taker should be recording any clinical events that come up during the discussion.

Clinical events can include:

- Unfavorable event
- Near miss
- Area for improvement
- Care plan recommendation

The program coordinator/note taker should discuss clinical events with the hospitalist after the session to confirm that all events were captured and appropriately classified during the conference

Clinical events should be categorized within the data collection document including:

- Issue topic (pharmacy, medicine, discharge, social work, other)
- Issue type (unfavorable event, near miss, area for improvement, care plan recommendation)
- Severity (low, medium, high)
- Impacted vs. detected
- Detailed issue description
- Detailed issue response

Data Collection: Care Transition Event Definitions

Topics	Definition
Pharmacy	Issue related to a change, discrepancy, or allergy in patients medication
Medicine	Issue related to patients medical management
Discharge	Issue that was directly related to patients discharge
Social Work	Issue related to patient social situation
Other	All other topics that do not fit the top four categories
Issue Types	**Definition**
Unfavorable Event	Negative outcome to patient in course of healthcare management
Near Miss	Event that could have had negative outcome on pt but did not
Area for Improvement	Area for lessons learned, growth, change in protocol, improvement of practices
Care Plan Recommendation	Change in care plan as a result of participation in intervention
Severity	**Definition**
Low	No impact to patient, minimal consequences
Medium	Minor, temporary impact on patient
High	Potential for serious health risk to patient
Impacted vs Detected	**Definition**
Impacted	Did the study find & change an issue
Detected	Did the study come across an issue but not change it/impact it

Tips & Tricks

Tips & Tricks:

Conferencing platform: Choose a HIPPA compliant video-conferencing platform. Recommend Google Meet or Zoom. After choosing a platform, keep the login-information the same each week.

IT support: Work with the SNF IT support and executive director to schedule a run-through"with each SNF to test out the video- conferencing platform prior to starting sessions. This is also helpful to establish contacts for IT troubleshooting as needed.

Web-Cams: Budget funds for web-cams that can be given out to SNFs free of charge. This is to encourage connection via video as opposed to via phone.

Session schedule: Identify a 1.5 to 2 hour time block per week that hospital team is available and create 10-15 min time slots within that period for each SNF. Use the logistics survey to schedule each SNF in a time slot.

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Lighthouse Nursing Care Center
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