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Preparing for an ECHO Session:

Two Days before Session:

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

2. Fill out the ECHO-CT Data Collection Document
    - Using the MRN 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.

3. Email each site separately the name of patient, echo ID and attach an intake form and confirm the time that their patients will be presented and ask them to fax the Medication list to us. The sites will email you back to confirm the time.

4. Send the list of patients with ECHO IDs and MRNs to the ECHO staff by 3pm two days before session

One Day before Session:

1. Send email to discharging team who cared for the ECHO CT patient, inviting them to participate.
    - Send email to the PCP and attending physician as well as the residents, doctors, nurses. Be sure to check the date when the order was signed to be sure that it was from the hospitalization in question.

2. The sites will send fax of the patients' medication list and the intake forms to us. Please save these faxes.

3. Create document of filled in clinical info for each patient—the case details. For each patient, please look up the following information in their 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 team the case details, the medication list/intake forms, and the finalized agenda to look over before the clinic.

Day of Session:

1. Print and photocopy the agenda and the case details for the team and bring to the session.
2. Update the data collection spreadsheet with information from the discussions
3. Send a follow-up email to hospitalist on any follow-up action items needed.

Typical Process Flow of an ECHO-CT Session

1) Give a brief summary of the case based on information from patient's notes (this should be 1-3 sentences)

2) Ask the facility how the patient is doing and if they have anything do add to the overview

3) Address the following issues surrounding the transition, as appropriate to the patient being discussed, with the SNF team:
   - Review transition notes from discharge paperwork, often including but not limited to:
     - ✓ staple removal
     - ✓ antibiotic course
     - ✓ INR check
     - ✓ labs
   - Review scheduled appointments and appointments that need to be scheduled
   - Review medications – pharmacist to provide input as related to medication reconciliation for each patient, if applicable.
   - Inquire about the goals of care
   - Identify and issues surrounding the patient's home environment

4) If the patient has any of the conditions listed in Table 1 below, please follow recommendations listed in Tables 1.

5) Help troubleshoot any problems with the rehab providers

6) Ask about anticipated date of discharge and any barriers to discharge

7) If time permits, conclude by asking if there is anything we can do better from our end

Table 1

Fractures

- ✓ Review medications that may contribute to falls and decreased bone mineral density, listed in Tables 2 and 3
- ✓ Initiate appropriate medication management with Calcium and Vitamin D. Unless contraindicated, consider 1250mg calcium carbonate and 1000IU of 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
- ✓ Monitor for resolution or worsening of infection

Heart Failure

- ✓ Insure appropriate monitoring of weight and volume status and encourage medication titration as indicated
- ✓ Review medication list with attention to inclusion

Data Collection:

The ECHO data collection spreadsheet 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
- Name of Attending who saw patient while admitted

Information Recorded after Echo Session for each patient:

- Record if patient as presented at Echo Conference (Yes/No)
- Record why patient was not presented at conference
- Date that patient was presented at conference
- Was a resident present (yes/no)
- Was the inpatient care team called to attend conference (yes/no)
- Was patient's PCP called to attend conference (yes/no)
- Name of presenter at SNF site
- Whether phone or video was used during discussion of patient

Reporting Clinical Events:

1) During Echo Conference, while each patient is discussed, a note taker will be recording any clinical events that come up during the discussion.

2) An clinical events can represent:
    - Unfavorable event
    - Near Miss
    - Area for Improvement
    - Care plan Recommendation
3) The session note taker should discuss with hospitalist after session to confirm clinical issues that were reported during conference

4) 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

Definitions:

Topics	**Definition**
Pharmacy	Issue related to a change/discrepancy 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