Appendix A: ECHO-Care Transitions Session Process

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

2. The facilitator asks the staff how the patient is doing and whether they have anything do add to the overview

3. Facilitator 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

4. The facilitator reviews scheduled appointments and appointments that need to be scheduled

5. The pharmacist reviews medications and provides input as related to medication reconciliation for each patient, if applicable

6. The case manager/social worker inquires about the goals of care (if applicable)

7. The case manager identifies any issues surrounding the patient's home environment (if applicable)

8. All team members helps troubleshoot any problems with the rehab providers

9. The facilitator asks about anticipated date of discharge and any barriers to discharge

10. Conclude by asking if there is anything that could have been improved during the patient's transition

11. After the session, complete any follow-up communications for questions that could not be answered during the session