Indian Country ECHO
Implementation Profile

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Indian Country ECHO participated in a study, led by Diffusion Associates, and funded by the Robert Wood Johnson Foundation. The purpose of this study was to document and share how ECHO is adopted, implemented and sustained across ECHO hubs and programs in the United States and Canada. This study was separate from, but endorsed by, the ECHO Institute.

This profile is based on an interview conducted December 2020 by Nagesh Rao, PhD, professor at Ohio University, and Troy Jorgensen, program manager Project ECHO, University of Nevada, who was also an implementation fellow working with Diffusion Associates on this study.

We begin this profile by sharing unique implementation insights from Indian Country ECHO.

ECHO Implementation Insights

Working with Intermediaries

Organizations keen to start ECHO programs for American Indian/Alaska Native persons health could connect with Indian Country ECHO to gain a comprehensive understanding about structure, staffing, finance, policies, collaboration, and approaches to cultural sensitivity for creating an ECHO hub and programs that fit the needs of specific tribes. Relatedly, they might consider utilizing the strong collaboration across the 12 Indian Health Boards to learn, to recruit experts, and to share best practices.

Centrality of Relationships

Given the history of trauma faced by Native Americans, it was critical to build authentic and long-term relationships with tribes and people. Visiting and having in-person interactions (post-COVID) with tribes was crucial to provide effective and trusted healthcare. The voices of Indigenous people need to be included in the design and implementation of such programs. Start from where the tribe members are and walk with them in their journey to good health. They know their history and culture best.

ECHO Model Adoption

In 2015, the Northwest Portland Area Indian Health Board (NPAIHB) learned about ECHO while researching ways they could assist the Indian Health Service (IHS) Tribal and Urban Indian Health Centers treat hepatitis C in their communities. Leaders from NPAIHB reached out to the ECHO Institute to learn more about Project ECHO. They formed a partnership, and the NPAIHB worked with the ECHO Institute to offer Hep C ECHOs for IHS Tribal and Urban Indian Health Centers. The ECHO Institute ran the program for two years.

The Indian Country ECHO began in 2017 with the goal of providing a full spectrum of ECHO services—led by a Native organization for the IHS Tribal and Urban Indian Health Centers. David Stephens, RN, joined

the Indian Country ECHO as clinic director. Eric Vinson joined Indian Country ECHO in 2018 as project manager. The goal of Indian Country ECHO was to provide access to quality healthcare for every individual in the 43 federally recognized tribes in Oregon, Washington, and Idaho, as well as for tribes throughout the nation by reducing barriers so clinicians can provide the care that patients deserve.

Indian Country ECHO followed regulations at the tribal level, the policies of NPAIHB, and varying state and federal policies. They also had a deep understanding of the sovereign nation status of tribes and developed culturally responsive ECHO programs. Indian Country ECHO advocated on behalf of individuals and tribes. For example, a patient in Indian Country's Trans and Gender-Affirming Care ECHO was going to a separate state for hormone therapy. Indian Country ECHO stepped in "to do our homework about the state where the patient is going, to figure out and advocate on behalf of the patient so they have access to treatment that they deserve." Indian Country ECHO staff also advocated to ensure that programs such as Medicaid were covering treatment. They showed state officials how prolonging Hep C care led to the patient's health worsening and incurring higher costs for healthcare systems.

With the support of NPAIHB, Stephens designed and implemented the first Hep C ECHO program created by and for the 43 tribes in the Northwest. This new ECHO program launched with an in-person one-day training on Hep C screening, treatment, and management. Bringing together participants from all 43 tribes helped to build trust between and among ECHO staff and the participants. Following the in-person event, the ECHO consisted of telehealth sessions for the rest of the program. Pre-COVID, Stephens and Vinson visited spoke sites regularly because it was important to maintain relationships with tribes. Stephens and Vinson attended immersion training provided by the EHCO Institute at the University of New Mexico.

Project ECHO was part of a larger and integrated set of health initiatives for the 43 tribes. Indian Country ECHO was mostly funded by federal awards and grants, with small grants from other funding agencies. Indian Country ECHO had 4.5 FTE across 15 programs.

ECHO Model Implementation

The ECHO Model seeks to build a learning community where "all teach, all learn." This is done by leveraging technology, by sharing best practices, through case-based learning, and using data. We asked respondents to tell us what "all teach, all learn" meant to them, and about how ECHO was practiced. Interviewees emphasized bi-directional learning when describing "all teach, all learn." ECHO faculty were described as learning from the spoke clinicians about the health of patients and their patients' backgrounds, types of treatments, and the communities and organizations in which clinicians provided care. They emphasized how spokes learned new clinical skills from experts, and learned from each other about the similarities and differences of the challenges faced by each community. Stephens described how the ECHO sessions led to system-level knowledge: "The one-hour ECHO sessions are a touch point, but there's so much more that is learned outside of just the TeleECHO session and case-based learning. It provides an opportunity and an insight into a lot of these larger system levels issues, which we can then work through with each presenting clinician."

"All teach, all learn" had an important cultural component to it when practiced with tribes. Stephens shared it was important to pay attention to the implicit cues in the tribe member's engagement: "We always ensure that indigenous voices are heard, respected, used, and prioritized. They are part of faculty. We make sure that our indigenous faculty speak first in giving recommendations and not

necessarily the specialist. A lot of unspoken ground rules are known in Indian Country, which don't necessarily need to be made explicit." Ensuring that the programs were culturally appropriate was a priority. This was achieved by developing relationships and being humble. Vinson shared, "We're not experts in any of the tribes that we're working with. They're the experts." Indian Country ECHO "meets people where they are" and worked to do what the tribes needed and wanted. This work was also a gift. Stephens and Vinson said they were fortunate to be invited by the tribes to learn about each tribe's culture.

Indian Country ECHO ensured that every tribe had access to technology so they could connect to ECHOs sessions. Vinson shared that many clinics lacked resources to purchase technology so staff would send out webcams and help to set them up and demonstrate use. Buying and distributing webcams may seem like a minor activity, but with limited funding, it was a major contribution for clinics and participating spokes.

Indian Country ECHO sessions followed the core design of the ECHO Model. Adaptations were made based on the requirements of each tribe. In-person training on the first day was common across programs and a way to develop relationships with clinicians and community members. Sessions included a didactic that was led by experts from the Alaskan Native Tribal Health Consortium, South Plains Tribal Health Board, the Eastern Band of Cherokee Tribe, Cherokee Nation, and academic experts. Cases came from the IHS Tribal and Urban Indian Health Centers. After a case was presented and discussed, a case manager worked with the clinic to assist with the patient's access to care. The faculty and program teams debriefed after each session and meet quarterly to plan programs and discuss quality improvement.

Best practices were also shared through a website accessible to all tribal participants. The website included templates and guidelines so if someone was looking to "create a medication-assisted treatment program, we've got something that's been synthesized from a few different tribes' policies and procedures. You can plug in your name and tweak it to meet your specific health program's situation." The website was important, but oral communication was highly valued and often persuasive among the tribe members: "Tribal members will look to other tribes to determine, 'Is this something worthwhile? Should I do this?' There's a value in the patience to see if something is going to be worthwhile for their efforts or not."

Indian Country ECHO conducted a needs assessment before starting ECHO programs. The Hep C ECHO, and other ECHO programs, also conducted assessments after each session to measure participants' knowledge, practice, and change.

Factors Influencing Implementation

Studies of program implementation identify context factors that can shape how a program was implemented. Such factors include leaders or champions, state and federal policies, funding, partnerships or collaborations, staffing, internal structures and processes, and monitoring for quality and fidelity. Not all of these factors play a role in how EHCO was implemented here or elsewhere. Below, we identify factors that emerged during the interview that appear to influence how Indian Country ECHO's programs were implemented.

Policy Environment and Funding

Indian Country ECHO followed regulations at the tribal level, the policies of the NPAIHB, varying state policies, and federal policies. The cultural differences and the myriad of policies made for a complex and unique ECHO hub. All funding came from federal grants, and this too created a policy environment that influenced the implementation of programs.

Inter-Organizational Environment and Networks

The federal government split the United States into 12 areas that provide healthcare for American Indian and Alaskan Indian tribes. Indian Country ECHO reached all 12 areas. It also drew on experts from academic institutions across the country. Indian Country ECHO was embedded in the NPAIHB, which was owned and operated by the 43 federally recognized tribes of Oregon, Washington, and Idaho. Each tribe was unique, each region was unique. NPAIHB coordinated with various Tribal Epidemiology Centers and tribal organizations and had "folks connecting all the way from Florida, on up to Maine, over to Alaska, and all throughout the Midwest and Southwest. A lot of folks for the Hepatitis-C ECHO have connected into the University of New Mexico." Partnerships and collaborations were central to how Indian Country ECHO implemented its programs.

Leadership

Stephens and Vinson were enthusiastic leaders committed to the goals of Indian Country ECHO. "There's a tremendous benefit of serving the tribes at the health board," said Stephens. "The northwest tribes are very open and willing to share some of these efforts across the country for all tribes to be able to access." Even though resources were limited, when COVID struck, NPAIHB asked Indian Country ECHO to share vital information about COVID with the 43 tribes. In response, Vinson said, "We'll make it happen. We have relationships with infectious disease docs, with medical epidemiologists. We can put this together." The ongoing commitment from Stephens and Vinson shaped the implementation of ECHO programs offered by this hub.

ECHO Vision and Sustainability

When asked about the vision for the hub in the next several years, Stephens explained that, with direction from the 43 tribes, Indian Country ECHO would like to expand and offer more ECHO programs. Vinson suggested that federal funding, though limited, should stay the same and not hamper their ECHO programs. He stressed the importance of funding tribal organizations. "We love our experts at the academic institutions, but let's see the money go to tribes and tribal organizations first, not the other way around," Vinson said.

Indian Country ECHO was planning to improve assessment by creating a 6-month and 12-month post program survey of participants. Vinson acknowledged the challenge of tracking patient outcomes, "It's been difficult. Take hepatitis C getting SVR12s [blood tests]. That requires going back to the present clinician and look through an electronic health record." Vinson added that there was an IHS electronic health records (EHR) available to all U.S. tribes, but since they were not integrated across the Indian Health facilities, interoperability was a significant issue.

Respondents

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