**Minnesota Rural Addiction ECHO**
**Implementation Profile**

*"We can relate because we know how their jobs go. We know what that clinic looks like. We know what their day-to-day looks like. We know the demands of their job."*

The Rural Addiction ECHO and the Rural Physician Assistant Program Addiction ECHO were part of 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.

Katie Stangl, ECHO project coordinator for the Rural Addiction and RPAP Addiction ECHOs, was a 2021 implementation fellow, along with 14 other fellows, and worked alongside Diffusion Associates on this study. Interviews for this profile were conducted in August 2021 by R. Sam Larson, PhD, director of Diffusion Associates, and Karen Fraase, ECHO director at Southern Illinois University School of Medicine and an implementation fellow in 2021.

We begin this profile by sharing unique implementation insights from the Minnesota Rural Addiction and Rural Physician Assistant Program (RPAP) Addiction ECHO programs.

## Key Learnings for ECHO Implementations

### *Stability through Transitions*

The Rural Addiction ECHO was the trademark program associated with two primary care physicians, both boarded in addiction medicine—Heather Bell, MD, and Kurt DeVine, MD, along with Stangl, the ECHO project coordinator. It was the "Kurt, Heather, and Katie Show." Within a one-year span, this program moved across three different organizations and had changes in funders. Yet, the program, then in its fifth year, was stable throughout these changes. Leaders stayed the same; their passion was unwavering. Participants were unaware of the institutional changes, though it certainly was on the minds of the physician leads as they considered where to find a place that was proud of the ECHO work and that would fit with their values. The Rural Addiction ECHO was robust and appeared impervious to institutional shifts.

### *Building from What Works*

The Rural Addiction ECHO was based on a successful program for rural addiction treatment that Bell and DeVine had implemented earlier. The RPAP Addiction ECHO was based partly on the Rural Addiction ECHO and built into a highly successful nine-month program for third-year medical students. Building from what was already working was a way to quickly scale out ECHO programs.

### *Normalizing by Keeping it Fun*

The Rural Addiction ECHO had a light touch for a serious topic. The ECHO was "not horribly serious; we're serious when we need to be." Jokes and banter were part of each session and of presentations about their work. Bell recounted speaking at a conference and somebody saying that they should not be making jokes at a conference about addiction. But he countered saying, "You know, our patients are

pretty funny too. I mean, they say some pretty funny things and they joke around. But most everyone loves our talks because it's something that has to be normalized, right?" DeVine noted, "We've done a lot of things that no one had done before to make it interesting and fun. And I think that's what kept it alive."

**ECHO Model Adoption**

The ECHO work led by Bell and DeVine started in 2016 with a State Innovation Model (SIM) grant to develop and implement an opioid stewardship program. As part of the SIM work, Bell and DeVine attended a National Rx Drug and Heroin Summit in 2016 where they then learned about Medication Assisted Treatment (MAT). They brought this information back to the Family Medical Center and St. Gabriel's Hospital in Little Falls, Minnesota. The outcomes from the SIM-funded program were very encouraging and the Department of Human Services (DHS) reached out to Bell and Devine saying, "Hey, we're looking at this thing called Project ECHO. We'd like you to work with Hennepin Health Care and Wayside Treatment Facility to do some type of an ECHO." The Minnesota Department of Health was also interested in scaling out the opioid stewardship and community collaboration program. At about the same time, legislation was proposed to help rural communities in Minnesota treat addiction in an effort to increase access to treatment/care.

In November of 2017, Bell and DeVine, along with Stangl, the newly hired ECHO coordinator, attended immersion training at the ECHO Institute at the University of New Mexico. The Minnesota Department of Human Services (DHS) staff were also in attendance. At immersion training, Sanjeev Arora, MD, encouraged Bell and DeVine to do their own program. Bell said, "We were nonconventional. We're not based out of a university; we are not researchers. We were literally rural family doctors at that point, by no means a specialist in anything except what we had done in Little Falls." Bell and DeVine, along with Stangl, returned to St. Gabriel's to launch the Rural Addiction ECHO Program. Adoption of ECHO was supported by the CEO at the time who was "very into this work. He was very supportive. He felt the mission of the facility and this ECHO was something that had to be done."

When the Rural Addiction ECHO launched in January 2018, it was based on the original program funded by the SIM grant. The program evolved to assist providers in gaining a waiver to prescribe buprenorphine/naloxone. The ECHO continued to change in response to the needs and interests of participants and new developments in treatment. Said Bell, "It became whatever we could think of that had anything to do with opioid prescribing and/or addiction. And that led us to get our board certification for addiction." The program was ongoing, with more than 150 sessions completed and an average weekly attendance of more than 80 participants. Funding to launch this ECHO came from the 21st Century Cures Act and awarded via the Minnesota Department of Human Services.

The RPAP Addiction ECHO was part of a larger Rural Physician Associate Program, a community-based educational experience for University of Minnesota third-year medical students who live and train in rural communities across Minnesota and western Wisconsin. Bell and DeVine went through this program as medical students and had mentored RPAP students. DeVine had the idea to take content and experiences from the Rural Addiction ECHO and bring it to RPAP students. In reflecting on the training of people in their mid- or late careers, DeVine realized that they needed to work upstream and focus on medical students where, Bell said, "There is something different about this generation of students and how they view the work and how they view disparities. They were different from our generation." Bell and DeVine approached the medical school and said, "Hey, what about this idea? While your students are in RPAP, let's add this addiction curriculum." The RPAP leadership at the

university agreed. The 16-session curriculum was co-developed by university leaders with Bell and DeVine. Funding for this ECHO came via the RPAP program and was limited to third-year medical students and had about 35 participants.

## 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" (ATAL) meant to them. A consistent theme expressed by Bell and DeVine was learning via a peer-to-peer network. As rural primary care physicians, Bell and DeVine were peers of the Rural Addiction ECHO participants. They talked about their own practices as rural physicians caring for their patients, which positively impacted the learning. Bell said, "We can relate because we know how their jobs go. We know what that clinic looks like. We know what their day-to-day looks like. We know the demands of their job." Bell and DeVine also learned from the participants noting that there was a "whole community of people who teach, and we're learning just like they are with the cases." Both commented that ATAL was exemplified when participants become speakers. DeVine said, "We've learned from them; they've taken content further. We're cross-pollinating. People who were participants became the teacher. Some of the ideas they bring forward are just amazing." He continued, "These people could start their own ECHO based on what they've learned."

"All teach, all learn" was also relational in nature. There was a "cross-directional flow of information" fostered by polling and personal relationships. Bell and DeVine wanted to "learn what participants want to know" and talked with them frequently. They were building a "network of providers who can pull on each other for care." The RPAP Addiction ECHO reinforced relationships among students. These third-year medical students were dispersed across the state after spending two years in one room with the same people all the time. The ECHO component of their RPAP experience "enables them to have face time with their friends, their peers."

Both ECHO programs relied on didactics. The Rural Addiction ECHO occurred on a near weekly basis and Bell and DeVine liked to keep the schedule flexible. Participants "let us know what they're seeing so we can find speakers and presenters that apply to given topics." Both were proactive in reaching out to experts across the country to present during ECHO sessions. They were "not shy" about asking people they meet to present for them. For example, DeVine went to a summit and heard a talk about stigma. He emailed the presenter and asked if they would present at an ECHO session. Stangl followed up with the invited speaker and provided the "nuts and bolts of what needs to be done. I helped to find a date and follow up on all the CME disclosures." Stangl kept a spreadsheet of all the topics; and while they may repeat a topic, there was not a lot of recycling considering that they had hosted more than 150 sessions of the Rural Addiction ECHO.

Didactics in the RPAP Addiction ECHO were more structured. The program had a set curriculum co-developed with the university. During the first year, outside speakers presented didactics. Feedback from students, and Bell and DeVine's own uncertainty about what would be presented, led to changes in the second year with fewer outside speakers and more reliance on Bell and DeVine presenting content, often adapting prior presentations to fit the curriculum and medical students' knowledge base. To keep students engaged, Bell and DeVine added polls for the students to answer throughout the talk.

Cases were fluid in the Rural Addiction ECHO. Participants and presenters were encouraged to present cases. They may or may not use a case form. Cases were also built from conversations. Whether planned

or spontaneous, cases were "triggered by simple questions and management. The kinds of things that if a rural doctor bumps into, they'll know what to do." In the RPAP Addiction ECHO, the original goal was to have students present cases at the end of the curriculum but that "didn't happen as smoothly as we wanted." The medical students were reticent to present cases and to share their thoughts on how they might respond to a hypothetical case. In the RPAP Addiction ECHO, Bell and DeVine frequently drew on their own experiences to present a case that aligned with the didactic.

## 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 ECHO was implemented here or elsewhere. Below, we identify factors that emerged during interviews that appear to influence how ECHO was implemented via the Rural Addiction ECHO and the RPAP Addiction ECHO programs.

### *Organizational Fit*

In the course of a single year, the work led by Bell and DeVine had been hosted by three different organizations. This work started in St. Gabriel's Health in Little Falls, Minn. The CEO at St. Gabriel's when ECHO was adopted was highly supportive. However, some of the older physicians there "did not appreciate what we were doing. We had some high prescribers that did not think that was a problem. We had a problem with stigma." And the attention that Bell and DeVine were receiving, including being named the 2021 Family Physicians of the Year by the Minnesota Academy of Family Physicians, was not welcomed by all. The supportive CEO left St. Gabriel's, and the new leadership was not as supportive, seeing time spent on ECHO, even though funded via grants, as distracting from primary care work.

Bell and DeVine, along with Stangl, joined MEnD Recovery Services where their ECHO work and passion were welcomed. Bell and Devine became co-medical directors for both MEnD Correctional Care, which provided medical care for patients incarcerated throughout many Minnesota County jails, and MEnD Recovery Services, an addiction clinic. The commitment looked good on paper, with "about .4 of each of their FTE coved by funds to support ECHO." Changes at MEnD, however, led to new responsibilities and challenges. The Department of Human Services (DHS) was concerned with these developments and felt the ECHO program, with Bell and DeVine on board since the beginning, may be best facilitated elsewhere.

At the time of the interview, DHS was opening the RFP application process. Stratis Health was later awarded the RFP and Bell and DeVine were continuing their Rural Addiction ECHO via Stratis Health. In addition, Bell and Devine resigned from MEnD in November 2021 and started at CentraCare Addiction Services in St. Cloud in March 2022. According to Bell, "We are excited about getting back to the 'roots' in primary care and maintaining addiction care, which is tightly connected to our mental health clinic and outpatient addiction treatment program."

### *Funding*

Initial funding for the Rural Addiction ECHO program came from the Department of Human Services. This funding appeared secure, but at one point in 2021, funding had to switch from a grant to a technical contract; and for a brief moment the team was uncertain if the ECHO program would continue. The

team had hoped for a five-year appropriation to fund this work but instead an RFP was announced. Stratis Health was awarded the grant and they worked with Bell and DeVine to continue the Rural Addiction ECHO program. The shift in who held the funds did not change the delivery of the program.

The RPAP Addiction program was no longer being funded from the University of Minnesota, but the work would continue in a modified format with the number of sessions reduced. Passion trumped funding for this program. Dr. Bell said, “Yeah, we’re in. Whether we get paid for it or not. We will sign in and do the ECHOs for them.”

As Bell and DeVine reflected on their history of working with the Rural Addiction ECHO program, they shared that funding was not a guarantee that “work” time can be allocated to projects. Even though Bell and DeVine had money from state grants to buy out their time, the release time was hard to come by. The reality was “except for the actual time of ECHO during our day, all the other work we do is outside of work. Like on our days off, on the weekends, on evenings.”

*Networks*

Enthusiasm and continued support for Bell and DeVine’s work were largely attributed to their robust network. They had frequent contact with Sanjeev Arora, MD, at the ECHO Institute, the developer of Project ECHO, and he had presented at the Rural Addiction ECHO several times. In addition, they had presented at MetaECHO, including having Stangl (coordinator) present. In addition, Bell and DeVine went to Washington, D.C., with the ECHO Institute team, to meet with legislators. Arora’s and the ECHO Institute's support elevated the work of Bell and DeVine. The network extended to working with partners in Michigan, via an addiction mini boot camp, and Alaska, where they spent two days sharing their knowledge and how they work. They also spoke about their ECHO work at the National Rx Drug and Heroin Summit where somebody from California reached out asked, "Hey, can we have the manual you wrote?" Based on this manual, the group from California was able to replicate the addiction ECHO program in their communities. Other ECHO hubs viewed Bell and DeVine as influencers.

Bell and DeVine tapped into a network of professionals within Minnesota and across the country who presented at ECHO sessions. They reached out to experts—those they knew and those they didn’t know—and asked them to present at an ECHO clinic. A diverse array of speakers was one of the reasons the program attracted so many participants after several years. It also kept Bell and DeVine’s ECHO spark going.

These networks, and external recognition of their work, helped to buoy the Rural Addiction ECHO as it navigated choppy organizational waters.

*“Teamness”*

Bell and DeVine played well off of and with each other; they were engaging. The Rural Addiction ECHO had affectionately been referred to as the “Kurt and Heather Show,” which Bell amended to the “Kurt, Heather and Katie show.” They were a tightly integrated team and consistently showed respect and gratitude to each other. When Bell and DeVine left St. Gabriel’s and then MEnD, they brought Stangl with them. In speaking about how just three people could do all of this work, Bell said, “We’ve been nonconventional from the beginning. We are not a university. We are not specialists. We have Katie.” Working as a team also helped to keep the experience constant for participants and generated energy for the trio.

**ECHO Vision, Sustainability and Replication**

When asked about the vision for their ECHO work in the future, several ideas came forward. The most pragmatic vision was to find a different home for ECHO, especially for the Rural Addiction ECHO. At the time of this interview, Bell and DeVine were talking with a nonprofit organization that could take the lead on the administrative aspects of the ECHO, including writing grants, and they would do the programmatic work. This subsequently happened. Devine said he doesn't "see an end in this ECHO, and we don't see an end in the programs that we do in the communities . . . But we're looking for a place that would be proud of this; that when people say, 'Well, this community program, funded through the Department of Health is from this institution,' they're proud of it."

Bell and DeVine shared several larger visions. One was to replicate the Rural Addiction ECHO across all 50 states. Bell said, "In my ideal world, we'd be able to do an ECHO for somebody in each state like a team, preferably a duplicated Kurt, Heather, and Katie team in each state." This could come about by hosting boot camps in each state and from there identifying a team similar to their own who could then take the lead in their state and "then have a separate ECHO where there was a team from each state. And then we could speak to not just addiction, we could talk about how the ECHO is working in the state." This, Bell said, "Would be the perfect world." Central to this vision was keeping the focus on developing a peer-to-peer network among rural physicians with leaders that had experience as rural primary care physicians and in addiction treatment. Projects in Michigan and Alaska suggested that spread of their approach to ECHO was possible.

ECHO could also be part of a larger vision that Bell and DeVine shared about developing a medical home for "people with addiction. So that they can come in, they can see the addiction doctor, they can see their mental health provider, their kids can have their well-child visit there with a primary care physician. And all of this in a non-stigmatized environment."

Advocacy was mentioned as part of a larger vision. Bell, in particular, expressed a desire to continue work similar to what she and DeVine engaged in with the ECHO Institute before the legislature. Bell said, "I want to still do advocacy. I love being able to go and testify before state and federal bodies, to really be able to help incite this change."

Specific to a vision for the RPAP Addiction ECHO, the grant supporting this work had ended. They could not continue the program as it was, and were now providing five 1.5-hour sessions—pro bono. As mentioned earlier, passion trumped funding for this team.

What will it take to achieve these visions, especially to ensure the continuation of the Rural Addiction ECHO? Funding for programs, certainly, but funding to also allow for significant changes that would allow for career shifts where the focus was on addiction treatment and ECHO was part of that; funding would allow a radical change in how both Bell and DeVine use their time. Funding was also linked to ensuring that Stangl can and will stay with the team. Says DeVine, "Honestly, the only challenge I see is keeping Katie through all of this, because doing it without her is almost impossible."

## Respondents

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