Northern New England ECHO Network
Implementation Profile

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The Northern New England Network (as represented by Qualidigm), the Health Resources and Services Administration (HRSA) Older Adult ECHO program, and the Healthy Acadia Medication Assisted Treatment (MAT) Expansion ECHO program 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.

Kayla Cole, then director, Center for Quality Improvement at the Maine Medical Center, and lead on NNE ECHO projects, was one of ten implementation fellows in 2020, and worked alongside Diffusion Associates in this study. Jay Mason, director, West Virginia Clinical and Translational Science Institute, Project ECHO, and a 2020 implementation fellow, and R. Sam Larson, PhD, director of Diffusion Associated, conducted interviews in September and October 2020 that are the basis of this profile.

We begin this profile by sharing unique implementation insights from the Northern New England ECHO Network, and its Health Resources and Services Administration (HRSA) Older Adult and the Healthy Acadia Medication Assisted Treatment (MAT) Expansion ECHO programs.

ECHO Implementation Insights

Benefits and Challenges to Multi-Organizational Collaborations

Collaboration was a central theme across interviews. The Northern New England ECHO Network illustrated how multiple organizations can collaborate to create an ECHO hub—an overarching structure that can support multiple ECHO programs. Within the NNE ECHO Network, Maine Quality Counts/Qualidigm led the operational and implementation support. Research, data, evaluation, and medical expertise were provided by partners. This particular collaboration worked across three states where rural populations were similar and face shared challenges. Keeping this type of collaboration together required someone to take a leadership role, and that was Maine Quality Counts/Qualidigm.

The collaborative HRSA grant supported the work of this tri-state group. Funds were allocated to each key partner to support their role. When the funding ended, so too did the active collaboration. The interest was there to continue with collaborative efforts, but self-funded projects and people shifted their attention as funding revenues and project purposes changed. Furthermore, a suggestion was raised that the collaborative nature of the work eroded due to new ECHO hubs and programs competing in the same geographic space.

Stability Across Organizational Transitions

Within the Northern New England ECHO Network collaborative, there was a great deal of flux by the operational/implementation lead partner. Maine Quality Counts was absorbed by Qualidigm. Then Qualidigm dissolved and the ECHO work moved to the Maine Medical Association. So much change within an already loosely connected network might have put an end to the ECHO work—but that was

not the case. The lead person for the ECHO work brought her ECHO expertise to each organization. And each organization recognized the importance and contribution of the ECHO program to their body of work. When this person left Maine Medical Association, however, no one picked up the ECHO role.

Rent-a-Hub

The hub collaborative support model, or "rent-a-hub," was one way to sustain capacity for ECHO work. Healthy Acadia wrote an ECHO program into their work and came to Qualidigm for the implementation support. It was easy for Qualidigm/Maine Quality Counts to set up this model "because a lot of health systems could come to us and felt comfortable with that because we weren't in competition in their eyes. Within the ECHO programs, we had clinicians from pretty much all the health systems in Maine that would join and share policies, share information, and work together because we were that neutral convener."

Organizations as Spokes

Participants or spokes can be organizations. For the HRSA Older Adult ECHO, the spokes consisted of community groups or organizations. For this program, small stipends to the organizations helped to ensure their participation and, more than that, recognized their time and commitment.

Robustness of the ECHO Model

Fidelity to the ECHO Model held even when the initiative was led by a tri-state collaboration, when the organizational host shifted, when funding was shared, when spokes were community organizations, and when only some of the program leaders attended immersion training. Further, even though the Northern New England ECHO Network was no longer operational and programs had been shuttered, the belief in the ECHO Model remained strong.

ECHO Model Adoption

Maine Quality Counts and Sanjeev Arora, MD, founder and director of Project ECHO, were instrumental in bringing the ECHO Model to Northern New England. The Maine Quality Counts team first learned about ECHO from the Weitzman Institute, who invited the team to observe and participate in ECHO sessions they were hosting. The Maine Quality Counts team realized how transformative case-based virtual education could be in addressing the rurality of the Northeast region. But Maine Quality Counts was a quality improvement organization and although they had many connections with medical care providers and clinicians, they did not provide direct patient care. So, they found partners who could bring complementary resources to the table. These partners included Citizens Health Initiative at the University of New Hampshire, the Vermont Program for Quality Health Care, the Northeast Telehealth Resource Center, and the AHECs serving Maine, Vermont, and New Hampshire. Collectively, these organizations inquired with the ECHO Institute about becoming a hub. They also wrote a regional ECHO network into a grant application to HRSA.

Staff from Maine Quality Counts, the Northeast Telehealth Resource Center, and the University of New England AHEC attended an ECHO immersion training program. While in New Mexico, they invited Arora to speak at the 2018 Maine Quality Counts Annual Conference, which had over 350 attendees from across New England. He agreed, and according to a respondent stated, "If I come to Maine, I'm not just coming for the Maine Quality Counts conference. I want to go to Vermont. I want to go to New

Hampshire. I want to meet as many people in each of those states as I can over a three-day period." Arora held approximately 45 meetings in three days in addition to being a keynote speaker. According to one respondent, "It was a marathon event with Dr. Arora doing a tour. We called it a 'barnstorming' tour."

The HRSA proposal was funded, which led to the formation of the Northern New England (NNE) ECHO Network. One of the primary goals of the NNE ECHO Network was to spread the utilization of Project ECHO throughout northern New England. The governance structure of the NNE ECHO Network as funded via HRSA was a shared leadership team with representatives from each of the formal network partners. The role of Maine Quality Counts, a nonprofit focused on healthcare quality improvement through clinician education, was designated as the operational, technical, and administrative lead for the NNE ECHO Network, overseeing budgets as well as coordinating the implementation of the HRSA ECHO programs. Along with Quality Counts, the Citizens Health Initiative at the University of New Hampshire and the Vermont Program for Quality Health Care provided strategic leadership and advised on program development and network oversight. The Northeast Telehealth Resource Center was responsible for network/program evaluation and the AHECs in Maine, Vermont, and New Hampshire conducted needs analysis and assisted with outreach. In this study, we focused on the role of Maine Quality Counts (and then later on Qualidigm) in the NNE ECHO Network as they had primary responsibility for implementing regional ECHO programs.

Each of the NNE ECHO Network member organizations signed partnership agreements with the ECHO Institute and sent one or two designees at a time to ECHO Institute immersion training in New Mexico as funding permitted. In doing so, the partner organizations developed internal expertise with implementing ECHO programs.

During the three-year HRSA grant, Maine Quality Counts went through two organizational transfers. First, Maine Quality Counts merged with Qualidigm, a health care quality improvement organization based in Connecticut. The change in corporate address put the HRSA grant in a county that did not meet the rural definition for HRSA. This required transferring the financial administration to the Vermont Program for Quality Health Care while all HRSA ECHO project activities continued to be delivered by Qualidgm. Toward the very end of the HRSA grant, Qualidgm dissolved, and the remaining work transferred with the key operational leader, Kayla Cole, to the Maine Medical Association.

The NNE ECHO Network brought together complementary skills from formal partner organizations in three different states that shared a similar rural population. The HRSA grant was the only shared funding mentioned by respondents and it had ended prior to our interviews. The NNE ECHO Network was not currently operating shared programs, though the parties continued to meet on an ad hoc basis and were committed to pooling funds across the three states to provide education on relevant topics for all three states. In the meantime, and as explicated below, additional funds to Maine Quality Counts and then Qualidgm enabled the operational team to provide additional implementation support for ECHO outside of the NNE ECHO Network.

HRSA Older Adult ECHO Programs

The HRSA Older Adult ECHO was funded through a HRSA grant in July of 2017. This three-year grant supported a sequence of three distinct ECHO programs. Our focus was on the third year of this grant and the HRSA Older Adult ECHO program. This ECHO program had community organizations serving in the role of spokes. Each community organization designated a community coordinator to facilitate the ECHO process for their community and the community coordinator received a small stipend. The role of

each community coordinator was to ensure the various community partners came together for the ECHO sessions and to coordinate their communities case presentation, communications, and meetings between ECHO sessions. Qualidigm had to find funding beyond the HRSA grant for community coordinator stipends. HRSA funding ended in June of 2020.

Healthy Acadia MAT Expansion ECHO

This program started from a Substance Abuse and Mental Health Services Administration (SAMSHA) grant received by Healthy Acadia. The SAMSHA grant included funding for an ECHO program to deliver education and build a network to expand clinical support for MAT care in the Downeast region. Healthy Acadia staff learned about Project ECHO from Maine Quality Counts. Healthy Acadia was not an ECHO and did not have the capacity to successfully deliver the ECHO program. They approached Maine Quality Counts and asked if they would host the ECHO program. This multi-year MAT Expansion ECHO program started with a short series of ECHO sessions focused on the basics of MAT prescribing, as many clinicians were new to MAT patient care. The focus then shifted into a two-year quality care program for patients on MAT and used case-based learning. Maine Quality Counts provided training and implementation support for the program. The Maine Quality Counts team referred to this type of ECHO partnership as a "rent a hub." Funding for this program had ended, although Healthy Acadia wanted to continue this work and potentially expand it.

The HRSA Older Adult ECHO and the Healthy Acadia MAT Expansion ECHO were adopted because ECHO was a best-practice delivery platform for education and sharing of practical experiences in a rural setting. The partnership adopting ECHO was different. For the HRSA grant, it was the Northern New England ECHO Network adopting the ECHO Model, with Maine Quality Counts/Paradigm being the operational partner. For the SAMHSA MAT Expansion ECHO program, Healthy Acadia adopted the model and partnered with Maine Quality Counts/Qualidigm to implement it.

ECHO Model Implementation

The ECHO Model seeks to build a learning community where "all teach, all learn." This is achieved by leveraging technology, sharing best practices, through case-based learning, and using data. We asked respondents to tell us what "all teach, all learn" meant to them. From the start, Maine Quality Counts grounded their approach to ECHO in adult learning theory—a scholarly focus of one of the initial leaders in the Northern New England ECHO Network. This respondent stated: "The idea in adult learning theory is that people learn best if they're in different roles. Sometimes you're learning from others and sometimes you're the one responsible for doing the teaching. By switching roles, you increase confidence and increase skills. The foundation of the ECHO Model is really around promoting those qualities."

The concept of role switching was carried out throughout ECHO sessions. For example, a spoke member might serve as an expert on a particular topic that was being discussed in that session, but in the next session, that same spoke member might be seeking advice on a different topic. A respondent with the HRSA Older Adult ECHO program stated: "I think as we went through these ECHO sessions we witnessed not only the community learning from the faculty, but the faculty learning from the communities." A similar idea was expressed by a medical lead in the Healthy Acadia Downeast MAT Expansion who shared: "I don't think I've been involved in an ECHO session yet where the case we just reviewed didn't transfer as learning and improvement into my daily practice and work. Though I may have a role as the faculty member, the innovations that the clinicians and partners were doing on the ground in this ECHO

were highly transferable. I literally find myself in case discussions with other employees sharing knowledge that I obtained from an ECHO session."

"All teach, all learn" was also expressed as learning that occurs among the spokes. One respondent talked about community initiatives being shared among the spokes where a spoke would say, "Oh, you are doing this innovative effort in X community. That's really cool. I wonder if we can replicate that in my community?" Another respondent commented on a "circle of information" where spokes were "reaching out to each other for questions and sometimes skipping over us . . . building relationships to keep learning after the ECHO."

On reflecting across ECHO programs, one respondent described "all teach, all learn" as being enabled by the "open, safe space to share ideas and dedicated time to do that. Which most of us usually wouldn't have otherwise." The HRSA Older Adult ECHO and the Healthy Acadia Downeast MAT Expansion ECHO reinforced "all teach, all learn" by following a consistent agenda and timeframe, which made the process familiar and encouraged open communication. One respondent mentioned that the session coordinators "facilitate sessions to elicit participation from folks." In addition, the faculty for both programs met for 15 or 20 minutes at the end of each session to debrief and "brainstorm about what worked and what could we do better to be more engaging or to get people to be less shy and participate more."

Keeping adult learning theory in mind, establishing relationships among and between all participants, and creating a space where spokes were comfortable speaking up and sharing information/suggestions, reinforced "all teach, all learn" across ECHO programs. "All teach, all learn" also continued beyond the session as resources were shared following an ECHO session for both of the programs.

Emerging from the NNE ECHO Network was an opportunity for Maine Quality Counts/Qualidigm to use its ECHO knowledge to support other organizations and initiatives that lacked the operational capacity to deliver quality ECHO programs. Referred to informally as a "rent-a-hub," Maine Quality Counts/Qualidigm developed a collaborative support model where an organization with content expertise and funding could partner with Maine Quality Counts/Qualidigm (and then Maine Medical Association) to plan and deliver ECHO programming. Support included, but was not limited to, education planning, program development and kick-off meetings, hosting/facilitating the ECHO sessions, and providing technical and evaluation support (including iECHO). As one respondent stated: "Organizations may have the medical expertise, but they don't have the technical training or ability to do all the project management aspects of implementing an ECHO program. So, we partner. Each partner organization brings their strengths to the table. It's a distributed hub model." Maine Quality Counts/Qualidigm worked closely with the ECHO Institute to ensure that fidelity of the ECHO Model was maintained while using this collaborative support model.

Factors Influencing Implementation

Studies of program implementation identify contextual factors that can shape how a program was implemented. These factors include leaders and champions, state and federal policies, funding, partnerships, and internal organizational structures and processes, monitoring for quality and fidelity, and staffing—including how people were trained and the characteristics of the people leading and supporting the program.

Not all of these factors play a role in how ECHO was implemented here or elsewhere, and some factors were more important than others. Below, we identify factors that emerged during interviews that influenced how the Northern New England ECHO Network, the HRSA Older Adult ECHO, and the Healthy Acadia MAT Expansion ECHO were implemented.

External Leadership and Champions

Arora encouraged the adoption of ECHO in the Northern New England area. Implementation, on the other hand, was influenced by leaders from different organizations in Vermont, New Hampshire, and Maine working together to define common goals and identify shared and relevant programming supported by a shared grant. An additional external influence was the Weitzman Institute. A respondent described a trip he and a colleague made to the Weitzman Institute, saying: "They [Weitzman Institute] provided an overview of how they run ECHO and did a lot of advocating on our behalf . . . and served as a mentor organization for us." This early mentoring may have influenced the decision of Maine Quality Counts/Qualidigm to develop a collaborative support model as the Weitzman Institute provided a similar service.

External Funding

The NNE ECHO Network was initiated by a grant from HRSA that funded the three-year Older Adult ECHO programs. The Older Adult ECHO programs also drew on additional sources of funding as the HRSA funds alone were insufficient. Healthy Acadia received funding from SAMHSA, which enabled them to partner with Maine Quality Counts/Qualidigm to operate ECHO programs in the Downeast portion of Maine. The HRSA and SAMHSA grants have closed; so, too, have the ECHO programs they supported.

External Partnerships

The Northern New England ECHO Network was, as mentioned before, a collaborative across three states. The three primary partners were focused on health care quality improvements. The hub also partnered with AHECs and the Northeast Telehealth Resource Center. The MAT Expansion ECHO was the result of an external partner, Healthy Acadia, approaching Maine Quality Counts/Qualidigm and asking them to provide implementation support.

External Policies

While no single policy appears to have influenced the implementation of the two programs we studied, multiple respondents talked about how a change in the state leadership, in particular the governor, led to greater optimism for state financial and cultural support for those struggling with substance use.

Internal Organizational Characteristics

The operational leadership for the Northern New England ECHO Network shifted in just over three years from Maine Quality Counts, to Qualidigm, to the Maine Medical Association. The impact of this change was moderated, however, by the constancy and continued presence of Cole, lead coordinator for ECHO program implementation. That said, these transitions resulted in a shift of focus for other staff and a loss of staff. Staff that remained, including Cole, had to take on new responsibilities, thereby redirecting some focus away from ECHO. As a result, quality control and fidelity were an ongoing challenge addressed through check-ins and debriefs.

Internal Leadership

Specific to Maine Quality Counts/Qualidigm, ECHO was not a primary focus for either organization. Still, ECHO has been influenced by leaders and, though not a primary focus, it was a priority for the organizations. The lead coordinator for operational work of the NNE ECHO Network, who also provided implementation support for the two ECHO programs we studied, divided her time among ECHO and non-ECHO work. She also transitioned between three organizations. Eventually leaving the third organization and ceasing to work on ECHO.

At the program level, leadership came not just from NNE ECHO Network or Maine Quality Counts/Qualidigm, but also from faculty and spokes. One respondent described a "grassroots kind of energy; people see our passion, our excitement." Faculty and staff familiar with ECHO also helped to lead by example, making it easy for newcomers to join.

ECHO Vision and Sustainability

When asked about the vision for the hub in the next several years, one respondent talked about the benefit of having an ECHO super hub in the Northeast Region, saying: "The ECHO Institute is great, but it's expensive to get there. We can better scale ECHO by having local capacity to provide training with support of the ECHO Institute." Respondents indicated that any such effort would require partnerships and "leveraging existing institutions that might have the capacity to take on some of the logistical parts of ECHO." A key consideration for becoming a superhub was finding a medical school partner, but Maine "doesn't have a huge state-funded medical school. So, it's challenging." The superhub goal was not necessarily specific to NNE ECHO Network or Maine Medical Association. Rather, a superhub may involve finding a higher education institution somewhere in New England that could become a regional superhub. A public university would, said one respondent, have "state funding built into their budget, and maybe additional flexibility to do the outreach work that is needed."

The future of the Northern New England ECHO Network was uncertain. When the HRSA funding ended, the NNE ECHO Network partners had "a lot of discussions around sustainability. Can we, still, maybe meet once a quarter and talk about what other ECHOs were happening through the various organizations and see if there's room to team up on something? If we're all running the same ECHO on the same topic, why not pool resources if we can. We're still looking at how we best do that moving forward. And that's our goal." While the door was open to discussions about how to continue the NNE ECHO Network, the Maine Medical Association was looking to see how it might leverage ECHO to work throughout the region and bring the medical associations together.

Developing new non-health-specific ECHO programs was also a longer-term goal. The rural landscape in Maine was dotted with small towns. As one respondent explained: "People don't get what rural is until we tell them that half of our population lives in communities of fewer than 5,000 people. We have nine cities in Maine with more than 20,000 people. We've got towns of 20 people." ECHO was seen as a way to work across geographic distances to bring multiple communities together to work on shared issues that may be non-clinical.

A superhub, continuation of NNE ECHO Network, and/or expansion of the ECHO role within the Maine Medical Association—all require additional funding. Finding funds and increasing financial sustainability was a goal described by all respondents. The lack of funding led to the dormancy of the NNE ECHO

Network, and the closure of the HRSA Older Adult ECHO and the Healthy Acadia Downeast MAT Expansion ECHO. The NNE ECHO Network members continued to reach out to each other, but no concrete plan for funding the tri-state effort was described. The HRSA Older Adult ECHO ended in June 2020. Program leaders expressed a desire to find additional funding to continue this ECHO in the future but, again, nothing specific was described. The Healthy Acadia Downeast MAT Expansion ECHO funding ended in September 2021. This program wanted to expand ECHO to include law enforcement as well as other community services. One respondent from MAT described the vision as follows: "During my work with Healthy Acadia, I've come to see where the gaps are in this rural area and where there was still stigma. My vision would be to have more participants and more faculty. Especially from even more sectors of society. I think law enforcement would be huge so that we can come together onto an educational platform and really talk about things that we're all thinking in a collective way. In an evidence-based way as well. To open up the floor to more folks, to have different opinions and different levels of expertise on certain topics." As of May 2021, this program had not secured funding to continue with or expand their work.

Respondents

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