7/12/17 Data Driven Justice: ECHO Knowledge Network

Presenters

- **Dr. Daniel Duhigg,** Medical Director for the CIT ECHO Knowledge Network

Updates

NACo: NACo is hosting the fifth in a series of webinars on the Stepping Up "Six Questions," which will feature key strategies for prioritizing policy, practice and funding improvements for people with mental illness in county jails. On this webinar, a national expert will provide an overview of key strategies on how county planning teams should prioritize action items identified through their process analysis and how to develop a detailed description of needs that include the projected outcomes of those actions and the anticipated funding requirements. There will also be a county official to share the planning prioritization process of their planning team. This webinar will be held on August 10, from 2:00pm – 3:15m ET. You can click here to register for this webinar.

The NACo Annual Conference was held July 21-24, 2017, in Franklin County, Ohio. There were a host of justice workshops at the conference, including Aligning Health and Justice Resources to Improve Health Outcomes, Fundamentals of a High-Functioning Pretrial System, Stepping Up Summits and much more! Many of these sessions were recorded and are available for viewing here. If you have any questions or need more information, please reach out to Kathy Rowings at krowings@naco.org.

Arnold Foundation: If you haven't already done so, please complete the DDJ Tech Tools survey that was previously sent around. The survey can be accessed by clicking here. If you have any questions or need more information, please reach out to Kathy Rowings at krowings@naco.org.

Key Takeaways

Extensions for Community Healthcare Outcomes (ECHO) is a model developed by the University of New Mexico that has been used to train many people. Dr. Sanjeev Arora, creator of ECHO, is a gastroenterologist in New Mexico. He was treating patients for Hepatitis C in his clinic, but was frustrated that many patients were unable to receive treatment because there were no specialists near where they lived. As a solution to this lack of primary care treatment options, Dr. Arora decided to use video conferencing technology to leverage scarce resources, which in this initial case was a Hepatitis C expert.

To address the Hepatitis C issue, ECHO trained physicians, physician assistants, nurse practitioners, nurses, pharmacists and educators on how to treat Hepatitis C. They used a web-based system to conduct teleECHO clinics, creating "knowledge networks" using case-based learning for guided practice. The idea is that cases in the real world are not as easy or clear cut as they are explained in text books and learning from real-world experiences helps individuals learn more effectively and apply knowledge more easily. Those on the networks learned how to approach complex cases because they were working through such cases over and over again.

The ECHO model also shares best practices and demonopolizes information that is often only available to experts or individuals in certain positions. Sharing treatment guidelines, medicine information and more with non-experts helps to reduce variation in treatment. ECHO also uses checklists and process that are well defined and delineated, and uses a web-based database to monitor outcomes.

Here is an example to help explain why the ECHO process is beneficial: When a person visits his or her primary health care provider and receives a referral, he/she was referred because the primary care provider did not have the answer to the patient's question or did not provide the needed service. The patient then must visit another health care provider that is an expert that can come up with the answer or perform the necessary procedure, and then return to the primary care provider. This service delivery method works but it has problems associated with it, including costs that are not always obvious. For example, the patient must travel; in states that are rural like New Mexico, if a patient has to travel 300 miles each way and they can't afford gas they likely will not see that expert and get help. It can also delay treatment, because the patient was already present with a primary health care provider but they now have to make appointments, travel and pay more to see the specialist.

There is also an issue of cultural literacy: When people are treated in their own communities there tend to be better outcomes. Knowing what resources are available locally, how people speak and what is important to them is helpful when treating them. There is also a missed opportunity between the health care providers because there is delayed communication in the primary health care provider receiving the report from the expert on the patient's problem. Finally, the primary health care provider never learned anything. There is no knowledge migration which does not make the primary care provider better suited to take care of the next patient that has that same problem.

What the ECHO model does is allow a primary care provider who has a question to connect to a network. In this network is a hub that has a specialist in the area that the primary care doctor has a question about. But there are also other health care providers connected to the network, too, and as these people are all connected to learn, the expertise grows and there is a diversity of opinions, feedback and recommendations. This makes the advice given much richer than a one-on-one experience. For example, a case is presented from primary care provider "A" to the network to receive information. The hub the provides information that is shared with primary care provider "A" but also is shared with the others that are on the network. This is demonopolizing expert information.

At the ECHO home base, it is really a team effort, where there is an expert present, a pharmacist, psychiatrist, a nurse manager and an IT expert. People connect from locations across the country and the world to discuss the cases. There is no direct patient care given, but experts at the hub provide information on best practices and advice on how to approach care, all while the people on the network are becoming experts. The clinic also works to bring everyone up to date on new information or best practices.

ECHO has since been expanded into areas such as HIV care, chronic pain care, addiction and psychiatry care and transgender care. When Project ECHO thinks about an area to expand into for a clinic, they are looking for common diseases and/or complex cases that really require the knowledge and help of an expert, have evolving treatments and medicines providers should stay up to date on and have serious outcomes of untreated disease/improved outcomes with disease management. ECHO transitioned into law enforcement—particularly situations where law enforcement is interacting with people who have mental illness—because this is a complex interaction that has evolving approaches and treatments.

ECHO partnered with an Albuquerque Police Department Crisis Intervention Team (CIT) detective to innovate the ECHO model and apply it to law enforcement. This partnership with the Albuquerque Police Department (APD) arose out of significant scrutiny the department received after the Department of Justice (DOJ) released a report in 2014 on the excessive use of force by the APD. The report found that too often the department used deadly force in an unconstitutional manner in their use of firearms, and that when there was a use of less-than-lethal force it was also done in an unconstitutional manner and was often used against persons with mental illness and in crisis. The DOJ found that this was not isolated or sporadic but a pattern or practice of excessive force that stemmed from systemic deficiencies in oversight, training and policy. The city of Albuquerque was sued which resulted in a settlement agreement. The problem was defined as there being no consistent guidance for best practices in the field for mental health and law enforcement and insufficient access to experts for police officers when dealing with difficult cases.

Traditionally, CIT is a 40-hour class that has no real upkeep. For many individuals after they complete the 40 hours of training, it's done—they may remember parts of the training but it may not be reinforced. Like any other skill, getting 40 hours of training and nothing else does not make one a lifelong expert, and the lack of feedback on the use of the skills may make those skills less used over time. Through the ECHO CIT model, when a person in law enforcement interacts with an individual exhibiting signs and symptoms of mental illness and the officer has questions about the situation afterwards and or wants to know what could be done differently, the officer can connect to the ECHO CIT network. The network has a CIT law enforcement expert and a psychiatrist on the line who connect to law enforcement from across the state and the country. There are people on the line who vary in rank and in types of communities. This allows for a diversity in the cases and recommendations provided. There is then a migration of the expertise out to the others in the police department and those that the departments interact with. There is a force multiplication which increases capacity and supports learning. Many of the people that connect have already gone through the 40 hours of training and ECHO CIT provides that ongoing training. The drawback of this is that it takes time and an officer dedicated to connecting and learning 90 minutes a week. It also requires leadership support, but the return on investment is enormous. ECHO CIT is reducing variation in training and helping with the implementation of CIT skills.

To do this, ECHO CIT applied for a three-year grant through the Bureau of Justice Assistance (BJA) for $250,000 under their Justice and Mental Health Collaboration Program. It was then a

collaboration between the Albuquerque Police Department; Project ECHO; Presbyterian Healthcare Services; CIT, Inc., and the University of New Mexico, Division of Community Behavioral Health. ECHO CIT has a curriculum focused on key areas needed by law enforcement; topics include "Behavioral Health 101," which reviews behavioral health diagnoses, symptoms and treatment and appropriate communication techniques for law enforcement officers interacting with an individual with a behavioral health diagnosis, such as Bipolar Disorder and Post-Traumatic Stress Disorder. The curriculum also covers officer self-care, techniques for stress management for officers and de-escalation/communication skills.

The ECHO CIT sessions do not obscure the identities of individuals to help the agencies to collaborate with each other because people move from jurisdiction to jurisdiction. Because of this, the sessions are closed, password protected and those who want to attend the session are screened. The first through third Tuesdays of the month are for law enforcement and first responders only and on the fourth Tuesday of each month other people can sign on to see the ECHO CIT model but not to see case presentation. The goal is to create a safe environment where mistakes can be discussed openly and free of scrutiny. The hub team for ECHO CIT includes a CIT detective, a psychiatrist, a social worker and a clinic coordinator.

ECHO's CIT clinic uses the Zoom teleconferencing platform, which allows for open communication. No one pays for ECHO and the software is provided free of charge. ECHO gives free access to Zoom, which allows for cases to be presented to the network for feedback and discussion. The whole point of ECHO is to demonopolize knowledge. Participants in ECHO agree that they will share the information freely. Joining ECHO provides access to a database of lectures and information. At the end of clinic sessions certificates of completion are distributed to allow people to account for the time they put in.

The benefits to law enforcement from using the ECHO model include training without travel or expense. ECHO CIT has spent time focusing on how to help organizations make change in addressing operating procedures. The project is based out of New Mexico but is connected in Washington, Oregon and New York with plans to do work in North Carolina. The ECHO CIT network was launched in January 2016 and began with 17 law enforcement agencies and is now up to 27.

Questions and Answers

Q: Is the expert available all the time in real time or are questions answered at a set time each week?
A: No, they are not available all the time. One of the reasons we use a video connection is because it facilitates people getting to know each other on the network. What tends to happen is people get to know each other and just call each other and ask what they suggest. This does informally occur which is a great thing. I saw that occur in the medical clinics where people still call me all the time about their psychiatric or chronic pain cases.

Q: What jurisdictions in North Carolina will you be working with?
A: I don't know the answer to that question.

Q: Have you thought about looping in probation or pretrial into this project so they can benefit as well?
A: Yes, the U.S. Probation and Pretrial Services has been part of the network from the start and it is a great collaboration. Because of course people go in and out of their services and some people are lifelong. What we end up seeing is collaboration between pretrial services and law enforcement agencies and great collaboration. It has worked out very well.

Q: Is there a way for jurisdictions to test out ECHO CIT without having to go through the whole training and officially signing on?
A: You do not have to go through the whole training. First come and see, that is the best way to see if this works for you or not. The person to connect with is Jennifer Earheart, Clinic Coordinator, at jearheart@cabq.gov. She is the contact person to help you get connected and if it is right for you then you and your team will be trained for free. We want people to see and experience this.

Q: How large of a network could Project ECHO support or how large of a hub could Project ECHO support? Are there plans to increase the number of hubs as the network grows?
A: Nobody has been able to find an answer as to how big is too big. I have been on ECHO clinics that have as little as four people and clinics with 70 people connected. You can't see all 70 faces on the screen, that is a limitation. We have never gotten so big that we said this is not working. I don't think there is any feeling to the size of the network. The question about other hubs is important. If we are talking about Hepatitis C, that disease is the same in Canada and Zimbabwe so it can be treated the same everywhere. It is important to have local hubs for law enforcement, because laws, regulations and resources differ based on location. While people are connecting from different states, what I would like to see are states developing their own hubs because they know what is local to them and they know their local laws. I can't give expert guidance on statutes in North Dakota but if there is a hub in North Dakota with an expert they can get better guidance.

Q: How easy was it to get law enforcement buy in for this? If people were skeptical, how did you get law enforcement engaged?
A: We began by identifying champions. There is a detective in the city who is a CIT expert and he knew who around the state in different agencies was interested in this area or would call him about cases and look for guidance. We started with them and the leadership from the various law enforcement agencies and we made the case to them, that this has been a proven model in medicine and this is how we think it will help. We held a boot camp where we invited leadership and champions from 17 agencies to come in and explained ECHO to them. We also did some cases with them as an example and showed them how to use the platform. The biggest challenge with ECHO is it takes some time to explain the model and it can't be done in a 30-second pitch. But after that it was about inviting people to come and see it and taking the time to have conversations such as the one today. You need leadership support because people need the time

to connect. What we found with all ECHO clinics in the idea of a champion. This process does not work well if you mandate people to do it because they then have a passive experience and don't really want to participate. You must find people in this area that have passion and will spread the word in their own agency. They will get people enthusiastic about how well it is working.