2013 Award for Outstanding Live Continuing Education Activity

In Recognition of an Organization Responsible for Innovation and Excellence in the Design, Educational Format, and Instructional Delivery of a Live Continuing Education Activity

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The EBAN Experience: An Equitable Health Collaborative

Introduction

The EBAN Experience was designed to connect care teams and community members through dialogue, experiential interprofessional education and health system redesign. The initiative engaged communities served by HealthPartners clinics and hospitals in Minnesota, trained teams to address community health issues, and provided participants with the tools and infrastructure needed to generate solutions to transform care delivery and reduce disparities in health. The interpersonal, intercultural approach necessitated a live educational format and an extended timeline of nearly a year. The EBAN Experience was supported in part by a grant from the Pfizer Medical Education Group.

EBAN is a symbol from the Asanti people of Ghana. It represents security, safety and trust. It was chosen as the symbol of the EBAN experience to represent the coming together of cultures to improve the health of all.

Award for Outstanding Live CE Activity (L to R): Carl Patow, Debra Bryan and Debra Curran of HealthPartners Institute for Education and Research. Not pictured: Jeanne Boettcher, Amy Murphy and Nancy Salazar of HealthPartners Institute for Education and Research, and Marcella de la Torre and Dianne O'Konski of Regions Hospital.

Design, Educational Format and Instructional Delivery

The EBAN Experience was designed as a highly experiential, multi-interventional, extended learning experience that included:

- Pre-activity familiarization of community members with quality improvement (QI) and the health system, and intercommunity networking
- Pre-activity preparatory webinars on principles of QI
- Interactive physical activities building teamwork and trust
- Bi-weekly live team meetings for team performance improvement activities for eight months
- Four large quarterly live meetings of all teams for cultural immersion, QI *just-in-time* coaching, panel discussions, interactive learning, case studies, sharing of cultural preferences and team experiences, and QI feedback sessions
- Presentations and discussion of films, specially commissioned for the EBAN Experience, on the experience of families in diverse cultures about health issues and the care system; facilitated discussions with the screenwriters, community members and actors
- Team presentations of QI team outcomes at a final live celebratory meeting with health system, community and state health leadership

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- Creation of a documentary film of the entire educational activity, including clips from the commissioned films and interviews with participants, health leaders and state health officials, for use as an educational tool by teams and for public television dissemination.

The EBAN Experience was based on the Accreditation Council for Graduate Medical Education/ American Board of Medical Specialties competencies of:

1. Interpersonal and communication skills that result in effective exchange of information and collaboration with patients, their families, their communities and health professionals to understand the impact of culture on health
2. Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
3. System-based practice, as manifested by actions that demonstrate an awareness of and response to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

This learning collaborative also incorporated these Alliance competencies:

1. Provide measurement tools and utilize reliable data to enable physician-learners to compare present levels of performance with optimum performance. (3.6)
2. Design activities with a cumulative goal of helping physicians, or teams of learners, to adopt change incrementally, assuring there is compatibility with present systems and advantage over present behaviors. (4.5)
3. Identify and collaborate with external partners that enhance effective CME activities. (5.2)

The course provided a platform for health professionals to co-learn with community members about health disparities and to implement improvements in care. The course used a plethora of process improvement methods, including charters, aim statements, plan-do-study-act cycles, QI tools and team facilitation. These methods, combined with clinic and plan data, provided teams with feedback to assess the progress of their efforts to adjust and improve care.

Additionally, the initiative included multiple external partners, including non-profit health organizations, local theater groups, public television and advocacy groups. A outside research organization identified pre- and post-improvements in the levels of cultural competency of the participants. The researchers also conducted round table discussions at the final session, where strengths and weaknesses of the collaborative were discussed. This information has been used to design subsequent learning collaboratives.

Gaps and Needs Assessment

In the last two decades Minnesota has experienced a large increase in its immigrant population. From 1990 to 2000 the foreign-born population increased by 37%. In addition, Minnesota has the largest Hmong and Somali populations in the country. Ethnic minority populations experience disproportionately higher levels of negative health outcomes and have limited health care access and a lower quality of care. Many providers have limited knowledge of the cultures of patients they serve in clinics and hospitals. The clinical needs assessment was based on health plan data. HealthPartners is an integrated financing and care delivery system in the upper Midwest that includes 1.4 million health plan members, 100 clinical sites and six hospitals. Since 2006, members in the health plan have been asked to voluntarily identify themselves by race and ethnicity. Over 95% of members/patients have provided this information. It is, therefore, possible to identify differences in health between specific populations served and all members of the health plan. Using this data, disparities were identified for preventive services, and teams were created to address the inequality of health outcomes. QI teams included: pediatric immunization rates in East African patients; advance directives in Black/ African-American patients; diabetes outcomes in East African and African-American patients; mammography screening in Latina, Somali, Hmong and African-American women; hospital readmission, effective pain control, colorectal cancer screenings, and fluoride varnish applications in minority, vulnerable and limited English proficiency patients. The learners' needs assessment was based on an assessment by the HealthPartners Equitable Care Fellows Committee that health care providers lack sufficient knowledge of cultural aspects of care and communities served. The Fellows have been conducting cultural awareness training at HealthPartners since 2004 through lectures, publications,

> ***I learned the importance of building trust and relationships with patients and communities. We need to take time to build relationships with communities before jumping to solutions.***
>
> **—Mammography Team Member**

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a self-guided learning program and discussions about race.

Objectives

The learning objectives identified for this activity were for teams to:

- Identify key QI principles and applications.
- Incorporate QI principles and measures to generate and test solutions to transform care delivery and reduce disparities in care.
- Work collaboratively with interdisciplinary teams and community members to solve problems.
- Recommend structural changes to systems and processes that will generate spread and value across HealthPartners.
- Develop an increased understanding of patients' perspectives by examining the impact of culture, barriers to care and socioeconomic variables.

Innovation and Excellence

The scale, scope, impact and outcomes of the EBAN Experience were unique for a live educational initiative. The creativity, energy and commitment of the participants were evidence of the special environment for learning that was created. Aspects that were particularly noteworthy and innovative are:

- The conscientious use of an educational design activating a learner's rational, emotional and operational senses as motivation to complete a lengthy, but effective, learning task
- Application of a collaborative model to address health equity
- Including community members in teams to bring patient-centeredness into the process
- Using real-time clinical data to inform multiple iterations of improvements in clinical care
- Attainment of outcomes at Moore's Levels 6 and 7 (patient and community health)
- Creation of ethnic films of patients' stories as a springboard for discussion
- Investing health leaders, state officials and the public in the outcomes of the initiative.

Model Event

The EBAN Experience was a *learning collaborative*, an educational model that has been replicated by other organizations. The Institute for Healthcare Improvement and the Alliance of Independent Academic Medical Centers are examples of organizations that have used collaboratives for large-scale QI efforts. Replication of the EBAN Experience is planned at multiple hospitals nationally as grant funding becomes available.

Summary

The EBAN experience was a highly innovative, large scale, complex model of CME, uniting over 120 individuals in four ethnic communities with health care professionals in care system redesign to measurably improve patient and population health. The success of the collaborative was seen in improved health outcomes, better understanding of cultural preferences and closer ties between ethnic communities and the health care system in Minnesota (see Figure 1 for a synopsis of the opportunities, actions and outcomes).

A Unique Experience Summarized

- Health professionals and community members came together to solve problems
- Program was of long duration and had an extended learning format
- Structural changes were made in clinical system design to improve care
- Health practitioners built partnerships with communities
- Platform was created for continued engagement with communities on health equity and social determinants of health
- Culturally specific films/theater were commissioned to raise awareness
- Screenplays were written by playwrights native to the culture
- Professional directors and actors (Mixed Blood Theatre) performed four screenplays that were filmed by Twin Cities Public Television
- Groups gathered to watch, discuss and reflect on the films, resulting in a heightened understanding of the effect of culture on health

Points for Practice

- Establishing rapport between community members and health professionals takes time and mutual respect. Trust and relationships are important to community members, especially early in team formation.
- For leadership support, try to select QI projects that are aligned with the long term health goals of the organization.
- Identify data streams that are already collected by your organization to support QI improvement goals or through routine quality surveys. Avoid chart reviews or creating new/untried data gathering procedures.

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Figure 1: EBAN Experience Outcomes

Clinical Improvement Opportunities	Team Actions	Clinical Outcomes
Increase pediatric immunization rates for children from East Africa.	Documented list of reasons why immunizations were refused. Engaged with community using nurse referrals to prompt patients to schedule return visits.	• Increased awareness of barriers and concerns. • Developed culturally specific messaging for parents about vaccine safety and timing. • Trained staff on communication methods. • Modified care model process.
Improve diabetes health outcomes through education for Ethiopian patients.	Conducted interpreter-staffed small and large group classes on culturally specific healthy eating and followed up with targeted case management. Utilized storytelling and culturally specific communication practices.	• 83% of participants who had baseline HbA1c $\geq$ 8% showed a decrease of at least 0.3% within 6 months. • 80% of participants who had baseline HbA1c $<$ 8% remained in control within 6 months.
Increase colorectal cancer screening rates for communities of color.	Determined cultural and knowledge barriers. Dispelled misinformation and offered an alternate test that was culturally more acceptable. Trained staff on new types of tests/procedures.	• Increased percentages of colorectal cancer screening in patients of color from 45.7% to 55.7%.
Decrease readmission rates for minority and limited English proficiency patients.	Held an open house to build relationships with community clinics with the hope of improving communication about transitions of care to reduce hospital readmissions.	• Established a direct phone line for readmission information. • Began conversations—work to continue.
Improve pain medication delivery time for minority and limited English proficiency in the emergency room (ER).	Communicated with ER physicians and produced *faces* pain scale cards to be distributed to adult patients to improve the way staff determined the pain level of patients. Educated clerks to better capture race information.	• The overall percentage of patients who received analgesia increased, and the initial disparities were essentially eliminated. • Increased the capture of race data in ER from 72.5% to 95.4%.
Increase colorectal cancer screening rates for Hmong and Somali patients.	Asked community members to provide feedback on colonoscopy procedure from their cultural perspective. Made outreach calls to overdue patients. Requested more interpreter assistance to reach non-English speaking patients.	• Staff gained greater awareness of patient preferences. • Outreach reminder calls, with the assistance of interpreters, improved screening rates. • Process changes are being developed, utilizing recommendations from community advisors, to prepare patients for a colonoscopy. • Intent to conduct more community outreach using *cultural ambassadors* to educate the communities on new types of colorectal cancer screening.
Increase breast cancer screening rates for Hmong and East African patients.	Held Hmong-specific mammography screening events. Listened to attendees to understand barriers.	• Learned that Hmong community needs more information on mammography screening, that Hmong radio stations should be used to spread messages, and that we should target adult children of patients, so they can influence their loved ones.
Increase rates of advance directives for African-American members.	Intentionally used QI techniques and tools to provide structure. Diverse team and community members provided significant insight into scripting and messaging needed.	• Improved the rate of Advance Directives in the African-American population of the Minnesota Senior Health Options program from 25% to 32% completion rate. • Narrowed the disparity gap between white and African-American patients from 25% to 21%.
Increase fluoride varnish and sealant rates for children from publicly insured families.	Piloted a new treatment plan for fluoride varnish to be applied at recall visits. Due to the success of pilot, plan spread to three additional clinics.	• Met goal of 15% improvement rate of pediatric varnish application for publicly insured patients.