Achieving Equity Through Organizational Change

Sunday, December 10, 2017
1:00 – 4:30 PM
Session Objectives

- Objective 1: Describe 5 key organizational change management strategies for creating sustainable change focused on equity in quality

- Objective 2: Highlight three organizations who were successful in implementing these strategies
# Agenda

<table>
<thead>
<tr>
<th>Welcome</th>
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| Disparities and Equity in the Time of Healthcare Transformation | Disparities Solutions Center  
Joseph R. Betancourt, MD, MPH |

| Overview of Key Strategies to Achieving Equity Through Organizational Change | Disparities Solutions Center  
Aswita Tan-McGrory, MBA, MSPH |

| Creating a Health Equity Policy | Blue Cross Blue Shield of Minnesota  
Patsy Riley, MPP |

Break (15 min)

| An Illustration of Cultural and Linguistic Competence | AnMed Health  
Juana Slade, BA, DCM |

| Strategies for Organizational Change | Children's Mercy Kansas City  
JC Cowden, MD, MPH |

Group Breakout Activity and Report Out
Improving Quality and Achieving Equity
Delivering Value in a Time of Healthcare Transformation

Joseph R. Betancourt, M.D., M.P.H.
Director, The Disparities Solutions Center
Senior Scientist, Mongan Institute for Health Policy
Director for Multicultural Education, Massachusetts General Hospital
Associate Professor of Medicine, Harvard Medical School
Outline

- High-Value, Transformation and Equity

- Key Drivers

- Lessons from the Field
High-Value in A Time of Healthcare Transformation

Value-based purchasing and health care reform will alter the way health care is delivered and financed; *quality* not quantity…

- **Increasing Access:** Assuring appropriate utilization
  - Linking to the PCMH, decreasing ED use & avoidable hospitalizations

- **Improving Quality:** Providing the best care
  - Importance of Wellness, Population Management

- **Controlling Cost:** Focusing on the Pressure Points
  - Importance of hot spotting and preventing readmissions, avoiding medical errors, and improving patient experience
  - Banding together and risk-sharing through ACO’s
Increasing Diversity

Health care organizations need to prepare staff to work with patients and colleagues from diverse cultural backgrounds.

Current and Projected Resident Population of the United States, 1998-2030

Diabetes-Related Death Rate, 2012
Deaths per 100,000 population

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Deaths per 100,000</th>
</tr>
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<tbody>
<tr>
<td>WHITE</td>
<td>22.8</td>
</tr>
<tr>
<td>BLACK</td>
<td>50.1</td>
</tr>
<tr>
<td>HISP/LTN</td>
<td>33.6</td>
</tr>
<tr>
<td>AI/AN</td>
<td>50.3</td>
</tr>
<tr>
<td>ASIAN/PI</td>
<td>18.4</td>
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</table>
What causes these Racial/Ethnic Disparities in Health?

- Social Determinants
- Access to Care
- Health Care?
Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) controlled for.

Many sources contribute to disparities—no one suspect, no one solution

- Navigation
- Communication
- Stereotyping
- Mistrust

Variations in care and quality, inefficiencies, costly care and poor outcomes are *the epitome of low-value*
Linking Disparities to Quality and Safety and the Pressure Points

- **Safe**
  - Minorities have more *medical errors* with greater clinical consequences

- **Effective**
  - Minorities received less *evidence-based care* (diabetes)

- **Patient-centered**
  - Minorities less likely to provide truly informed consent; some poorer *patient experience*

- **Timely**
  - Minorities more likely to *wait* for same procedure (transplant)

- **Efficient**
  - Minorities experience more *test ordering* in ED due to poor communication

- **Equitable**
  - No variation in outcomes

- **Also**
  - Minorities have *more CHF readmissions, and avoidable hospitalizations*
IOM’s Unequal Treatment

www.nap.edu

Recommendations

◆ Increase awareness of existence of disparities

◆ Address systems of care
  – Support race/ethnicity data collection, quality improvement, evidence-based guidelines, multidisciplinary teams, community outreach
  – Improve workforce diversity
  – Facilitate interpretation services

◆ Provider education
  – Health Disparities, Cultural Competence, Clinical Decisionmaking

◆ Patient education (navigation, activation)

◆ Research
  – Promising strategies, Barriers to eliminating disparities
Preparing for the Future

- Addressing variations in quality—such as racial/ethnic disparities in health care—will be essential going forward if we are to achieve equity, high-performance and high-value.

- This is not just about equity for equity’s sake—cost is key—as equity connects to all areas of quality:
  - Population Management
  - Transitions of Care and Readmissions
  - Appropriate Utilization and Avoidable Hospitalizations
  - Patient Safety
  - Patient Experience

- Healthcare organizations ignore this at their own peril…action will separate winners from losers…
Organizational Change Management For Health Equity: Perspectives From The Disparities Leadership Program

• JR Betancourt, A Tan-McGrory, KS Kenst, TH Phan and L Lopez. Organizational Change Management For Health Equity: Perspectives From The Disparities Leadership Program. *Health Affairs* 36, no. 6 (2017): 1095-1101
Disparities Leadership Program Goals

• Develop cadre of leaders in health care equipped with:
  – Knowledge of disparities, root causes, research-to-date
  – Cutting-edge QI strat’s for identifying/addressing disparities
  – Leadership skills to implement and transform organizations

• Assist individuals and organizations to:
  – Create a strategic plan to address disparities, or
  – Advance or improve an ongoing project, and
  – Be prepared to meet new standards from the JC, NCQA, and PPACA
DLP Organizations
32 states
Commonwealth of Puerto Rico
Canada, Switzerland
Study Data & Methods

• 2007 – 2017 ten cohorts but excluded current one
• 9 years of survey data
• 115 organizations
• Excluded those that were not hospitals, health plans, community health centers
• Final survey results of 97 unique organizations from 2007 – 2016
• 22 organizations of the 97 sent an additional team resulting in a total of 119 team/surveys
The Importance of Organizational Change Management for Health Equity

• Know who to involve
  – Establish a powerful guiding coalition
  – Involve both leadership and middle management
  – Develop cross collaborations

• Shape Organizational Culture
  – Disparities efforts anchored to current culture, or equity as part of quality
The Importance of Organizational Change Management for Health Equity

- Create Urgency, Vision, and Make the Rational and Emotional Case
  - Leadership buy-in & Benchmarking with external orgs creates urgency
  - Rocket pitch as a way to clarify your vision
  - Combining data with a personal story
  - Communication strategy, branding & marketing
The Importance of Organizational Change Management for Health Equity

• Engage Your Organization and Your Audience
  – Align with key stakeholders and share vision early and often
  – Continuous engagement through creation of short term wins such as awards, dissemination, benchmarking work or publications
  – Senior leadership models new behavior- e.g. Chiefs request data by R/E
The Importance of Organizational Change Management for Health Equity

• Harness the Power of a Collaborative Network
  – Develop strategic leadership skills
    • Anticipate changing environment
    • Promote a culture of learning
    • Challenge assumptions and encourage divergent points of view.
BLUE CROSS BLUE SHIELD OF MINNESOTA
CREATING A HEALTH EQUITY POLICY

Patsy Riley
Chief Government Officer & SVP
December 10, 2017
BLUE CROSS BLUE SHIELD OF MINNESOTA BACKGROUND

Enrollment
• Largest non-profit health plan in Minnesota – 2.9M members
• 950,000 Medicare and Medicaid enrollees

Mission & Strategy
• “We make a healthy difference in peoples lives”
• Healthy Communities one of 4 strategic pillars in 2017-2020 Strategic Plan

Quality
• 5 Star rating for Medicare and Part D plans
• 85 year commitment to improving health

Equity Focus
• Health Equity major strategic focus since 2015
• 9 Blue Cross employees (6 officers) participated in the Disparities Leadership Program (DLP) 2015-2016 cohort
• Decision made in April 2017 to create a BCBSMN Health Equity Policy to accelerate efforts to reduce health disparities in MN
• Minnesota consistently ranks as one of the healthiest states in the country, but we have some of the largest health disparities in the nation.
  • Nearly 1800 deaths could be avoided if all residents had fair chance to be healthy
• BCBSMN is uniquely positioned to address health disparities due to our scale, leadership commitment and history of taking on tough issues (i.e. tobacco).
• 2016 Governor Dayton declaration to reduce health disparities.
• Cultural and Ethnic Communities Leadership Council (CECLC) established in 2016 to monitor state’s progress (external).
• BCBSMN Health Equity Integration Council established in 2016 to accelerate progress.

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Percentage/Rate</th>
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<tr>
<td>2x mortality rate for African American infants compared to white</td>
<td>2x</td>
</tr>
<tr>
<td>3.5X mortality rate for American Indians in Twin Cities compared to other racial groups</td>
<td>3.5X</td>
</tr>
<tr>
<td>22% Somali immigrants screened for colorectal cancer compared to 70% of whites</td>
<td>22% PERCENT</td>
</tr>
<tr>
<td>25% Native Americans receive optimal diabetes care compared to 41% of whites</td>
<td>25% PERCENT</td>
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## BCBSMN HEALTH EQUITY - WHAT

The BCBSMN Health Equity policy will ensure:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Consumerism</td>
<td>Development of relevant services, products and programs while serving people in communities where they live.</td>
</tr>
<tr>
<td>Diversity and Inclusion</td>
<td>Hiring of a diverse and inclusive workforce that embraces a variety of skills, experience and perspectives and reflects the population we serve.</td>
</tr>
<tr>
<td>Partnerships</td>
<td>Utilizing strategic relationships with vendors, community organizations and providers to achieve our mission.</td>
</tr>
<tr>
<td>Strategic Integration</td>
<td>Integrating health equity principles and capabilities into our value proposition, strategic plan and individual and corporate goals.</td>
</tr>
<tr>
<td>Decision Making</td>
<td>Health Equity analysis will be conducted before business decisions are made.</td>
</tr>
<tr>
<td>Leadership Engagement</td>
<td>Health Equity Integration Council will educate, support, monitor and report on progress to Executive Leadership.</td>
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LESSONS LEARNED FROM DISPARITIES
LEADERSHIP PROGRAM
HEALTH EQUITY POLICY - HOW
KNOW WHO TO INVOLVE

✓ Health Equity Council comprised of leaders from across the Company including 7 officers and representatives from the Center for Prevention and the Foundation.

✓ Inspired by Minnesota Department of Human Services Health Equity Policy approved in 2016.

✓ Motivated by CECLC leadership challenge at joint meeting in February

✓ Health Equity policy work created focus for enterprise wide efforts to address health disparities.
SHAPE ORGANIZATIONAL CULTURE

✓ Every aspect of Blue Cross business is guided by policies and procedures – Medical Management, Human Resources, Procurement, Compliance, Network Contracting, Legal.

✓ Equity policy creates shared understanding and consistent approach to ensuring a lens on health equity for future business decisions.

✓ Health Equity Integration Council will collaborate with Enterprise Risk Management to build health equity efforts into corporate heat map which is monitored every year and shared with the audit committee of the Blue Cross board.
CREATE URGENCY, VISION AND MAKE THE RATIONAL AND EMOTIONAL CASE

✓ CECLC chair (also BCBSMN Director of Health Equity Advocacy) and BCBSMN Health Equity Integration Director are both respected thought leaders in MN and influential with Blue Cross employees.

✓ We benchmark several areas now, i.e. Procurement, Human Resources, Net promoter score. Equity policy monitoring will increase focus, impact and measurement.

✓ Employee health equity survey findings accelerate business case for health equity policy.

✓ Getting the Health Equity policy approved by end of 2017 was personal to me and a strong motivator for the team.
ENGAGE YOUR ORGANIZATION AND YOUR AUDIENCE

✓ We held meetings with business areas across the enterprise to share vision and draft policy. All members of committee shared this effort.
✓ We set up a calendar of events/ initiatives throughout 2017 to keep health equity on the radar.
  − Health Equity Month – April
  − Health Equity Survey – June
  − Health Equity Coach Training – on going
  − Health literacy ambassadors – on going
  − Racial justice facilitators – on going
  − Intercultural Development Inventory taken by 100 leaders
  − Launched inaugural Health Equity Award - August
This will happen organically as we implement the Health Equity policy throughout the organization over the next 2 years.

Some areas are ready to start now (Coalition of the willing or early adapters)

- Procurement – Supplier diversity
- Human Resources – Employees of color, Retention statistics
- Marketing – net promoter score
- Government Programs – RFP for culturally effective vendors
- Provider network – build into contracts
- Medical Management – capabilities needed to effectively work with diverse members

Exploring adding Health Equity Policy adoption to corporate incentive plan.

The work will be promoted externally as we continue to get it right on the inside.

Continue to work with Minnesota DLP alums to force multiply efforts.
APPENDIX

• Health Equity Business Strategy
• Equity Policy: A Priority for moving Health Forward
• Equity and Health Equity Policy (CSR 1-01)
Break (15 min)
2:25-2:40 pm
AnMed Health:
An Illustration of Cultural and Linguistic Competence

Institute for Healthcare Improvement
National Forum on Quality Improvement in Health Care
SL2: Achieving Equity Through Organizational Change
Orlando World Marriott Resort & Convention Center
Sunday, December 10, 2017

Juana S. Slade, CDM, CCF
Chief Diversity Officer and Director of Diversity & Language Services
AnMed Health
Anderson, South Carolina
Our Mission

to passionately blend the art of caring with the science of medicine to optimize the health of our patients, staff and community

Our Vision

to be recognized and celebrated as the gold standard for healthcare quality and community health improvement
AnMed Health Quick Facts

✓ 690 Beds
✓ Level II Trauma Center
✓ ED Visits: 112,329
✓ Medical Staff: 466
✓ Employees: 3,900

Uncompromising Excellence. Commitment to Care.
Reframing the Conversation

Diversity

Traditional  ➔  Inclusive

The Secret Sauce!...DOCUMENTATION

Most of the time  ➔  Every patient, every time

“The science of different-ness.”
John A. Miller, Jr. LFACHE
President Emeritus
Chief Collaborative Officer

Administration, Human Resources, Medical Staff, Financial Services, Quality/Safety Nursing/Patient Care Services, Emergency Services, Women’s Health, Children’s Health, General Counsel, Community Relations, Public Relations, Corporate Compliance, Internal and External Stakeholders, Patients, Families, Health Information Management (Medical Records,) Local, National and International Corporate Communities, Training and Organizational Development, Physician Network Services, Regional Colleges and Universities, etc.
2011 – 2013 The Perfect Cultural Competency Storm

✓ Enhance Culturally and Linguistically Appropriate Service Standards (CLAS)

✓ Joint Commission’s Roadmap Advancing Effective Communication, Cultural Competence and Patient- and Family-Centered Communication Standards

✓ National Call to Action

✓ Social Determinants of Health

✓ The Triple Aim
Our Project
Disparities Leadership Program
AnMed Health: Disparities Dashboard

Abstract
The goal of our project was to research and develop a disparities dashboard to identify and strategically address AnMed Health’s most vulnerable, underserved and costly patient populations. The disparities dashboard is adjunct to our system-wide quality measures and management strategies.
Project Objectives

I. Establish dashboard implementation team
II. Establish dashboard framework
III. Identify priority populations
IV. System engagement
V. Measure, monitor, enhance
Project Elements

Administrative /Executive Support

Competing organizational priorities
  • Moving disparities ‘conversations’ forward

Established dashboard framework
  • Methodology and Data Set

Physician Sponsor
  • Matt Cline, MD, Director, Family Medicine Residency Program

Resources / Implementation Team Talent
Dashboard Components

Quality
- Appropriate Care Scores
  - HF; AMI; CAP; SCIP
- Patient Satisfaction
  - H-CAHPS
- Readmissions

Disparities
- Diversity Snapshot
  - Service Volumes
  - Business Line Analysis
- Language Services
Challenges and Opportunities

Medical Sponsorship
Inpatient Focus
Intervention Team Transition
Collaborative Opportunities
Executive Transition
Progress!!

✓ ED Case Management and Discharge Planning
✓ SC Health Outcomes Program (HOP)
✓ Video Remote Interpreting
✓ Year 3 Data Language Service Compliance Plan
✓ Internal Interpretation Service Call Center
✓ Quality/Safety
✓ Industry Leadership: EOC/123/ The SC Alliance/IFD Transition
✓ Project SEARCH :SC Voc Rehabilitation
✓ CONNECT2017
✓ The Sky finally fell!!!!!!
Food for Thought

✓ Collaboration

✓ Qualitative and Quantitative Intelligence

✓ Expect the Unexpected

✓ Engage a talented, diversity team

✓ Consider the principle of tight-loose-tight
Know Who to Involve
Know Who to Involve
Shape Organizational Culture

Center for Clinical Effectiveness
(Quality and Safety)
Shape Organizational Culture

Center for Clinical Effectiveness (Quality and Safety)

Clinical Support
Clinical Safety
Education
Equity and Diversity
Evidence Based Practice
Family Centered Care
Performance Improvement
Quality Improvement
Regulatory Readiness
Simulation

The IHI Triple Aim

Population Health
Experience of Care
Per Capita Cost
Shape Organizational Culture
Health Equity Strategic Framework

Health Equity Strategic Framework

Children’s Mercy Kansas City
Equity and Diversity Framework & Aims

Leadership

1. Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.
2. Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.
3. Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.
4. Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.
5. Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.
6. Commit to cultural competency through system-wide approaches that are articulated through written policies, practices, procedures, and programs.
7. Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.

Patient-Provider Communication

1. Implement language access planning in any area where care is delivered.
2. Offer and provide language access resources in the patient’s primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.
3. Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the health care experience.
4. Maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high quality communication.
5. Translate all vital documents, at a minimum, into the identified threshold languages for the community that is eligible to be served.
6. Translate written materials that are not considered vital when it is determined that a printed translation is needed for effective communication.
7. Ensure that a qualified interpreter reads a document to a patient if the patient cannot read the translated document.
8. Use “teach back” as a patient engagement tool to enhance communication between the health care provider and the patient during clinical encounters.
9. Communicate key information about the proposed treatments or procedures for which patients are being asked to provide informed consent.
10. Include family members in health care decisions, when requested by the patient, when providing care for culturally diverse populations.

Care Delivery and Supportive Mechanisms

1. If requested by the patient, provide resources such as provider directories that indicate the languages providers speak, so that patients can have access to this information.
2. Develop and implement a comprehensive care plan that addresses cultural concerns.
3. Consider cultural, spiritual and religious beliefs that may complement or conflict with standard medical care.
4. Adapt the physical environment where the health care is being delivered to represent the culture of the populations who access their health care in that environment.
5. Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking health care.
6. Explore, evaluate and consider the use of multimedia approaches and health information technology to enable the provision of health care services that are patient and family centered.

Workforce Diversity and Inclusion

1. Recruit and hire ethnically diverse providers and staff at all levels. Actively promote the retention of a culturally diverse workforce through organizational policies and programs.
2. Assure availability of a trustworthy process for the expression of employee grievances and concerns regarding race, ethnicity, language and other diverse characteristics that protects the integrity and confidentiality of employees.
3. Implement reward and recognition programs to recognize specific individuals, initiatives and programs within the organization that promote cultural competency.
### Education and Training

1. Implement education and training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state and local laws, regulations and organizational policies.
2. Integrate cultural knowledge and processes of culturally appropriate care into residency, fellowship and medical student curricula, partnering with learners’ home educational institutions as appropriate.
3. Connect workforce to education and training opportunities outside of the organization that may enhance their cultural competence abilities.
4. Regularly assess attitudes, practices, policies and structures of all staff as a necessary, effective and systematic way to plan for and incorporate cultural competency within an organization.

### Data Collection, Public Accountability, and Quality Improvement

1. Ensure that, at a minimum, data on an individual patient’s race and ethnicity (utilizing national standards and best practice evidence) and primary written and spoken language are collected in health records and integrated into the organization’s management information systems. Periodically update the language information.
2. Maintain a current demographic, cultural and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural characteristics of the service area.
3. Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity and primary written and spoken language information collected by the institution.
4. Publicly report data for the applicable NQI-endorsed disparities-sensitive national voluntary consensus standards for ambulatory care stratified by race/ethnicity and primary written and spoken language.
5. Regularly make available to the public information about progress and successful innovations in implementing culturally competent programs and provide public notice in communities about the availability of this information.
6. Assess and improve patient- and family-centered communication on an ongoing basis.
7. Any surveys created by or conducted by the organization must collect race, ethnicity and primary written and spoken language, and analysis and results must be stratified by race, ethnicity and primary written and spoken language.
8. Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing and promptly and equitably resolving cross-cultural conflicts or complaints by patients or between organizational staff.

### Community Engagement

1. Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing and evaluating the effectiveness of hospital cultural competency activities.
2. Health care professionals and organizations should engage communities in building their assets as vehicles for improving health outcomes.
3. Market culturally competent services to the community to ensure that communities that need services receive the information.

### Research

1. Provide foundational education to diverse communities regarding topics of research and the research process.
2. Provide education to researchers about recruitment of diverse subjects into research studies.
3. Create and communicate organizational expectations regarding the engagement of diverse communities in subject recruitment efforts.
4. Provide Institutional Review Board processes that facilitate the engagement of diverse communities by researchers.
5. Identify, support and create funding opportunities to encourage the engagement of diverse communities in research and to foster the study of cultural competence and health equity.
6. Use the methodology of community-based participatory research when conducting research in the community as a collaborative approach that equitably involves all stakeholders in the research process.
Organizational Strategic Framework

Mission, Vision, Values Goals

Vision 2022
Be a national and international leader recognized for advancing pediatric health and delivering optimal health outcomes through innovation and a high-value, integrated system of care

Public Policy Leadership

Innovation Goals 2017

Demonstrate Quality Outcomes
A. Demonstrate quality, safety, and clinical effectiveness

Improve Performance
B. Improve processes, increase capacity for innovation and service excellence, and strengthen financial position

Strengthen Market Position
C. Maintain CMH’s market position in the Metro area and grow it throughout the region

Deliver Value
D. Develop an integrated pediatric health care system that demonstrates value, expertise, and efficiency

E. Enhance the research capabilities and accomplishments of CMH and strengthen the quality of the educational experiences

Values
Accountability • Clinical Excellence • Continuous Improvement • Empowerment
Transparency • Respect • Teamwork

Mission
Improve the health and well-being of children by providing comprehensive family-centered health care, committing to the highest level of clinical and psychosocial care, and exhibiting research, educational and service excellence

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Mapping Strategies to Make a Clear Case
Harness Collaborative Networks

Pediatric Health Equity Collaborative (PHEC)
- Hosted by the Disparities Solutions Center (Boston)
- 12 pediatric hospitals focused on disparities leadership
- White paper on REaL data collection
Harness Collaborative Networks

Children’s Hospitals’
Solutions for
Patient Safety
Every patient. Every day.

SPS Health Equity Group
>100 Children’s Hospitals in US and Canada

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Contact

John (JC) Cowden  
jdcowden@cmh.edu  
816-302-3811
Group Breakout Activity and Report Out (60 min)
3:20-4:20 pm
For More Information About
The Disparities Leadership Program

www.mghdisparitiessolutions.org

Contact: Aswita Tan-McGrory, MBA, MSPH
Deputy Director
atanmcgrory@partners.org
617-643-2916
Please turn in evaluations to Aswita Tan-McGrory.

Thank you!