Health Equity: Why it Matters and How to Achieve it

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Health inequities—defined by the World Health Organization as systematic differences in the health status of different population groups—have been in the national spotlight for years, which isn't surprising given that the U.S. ranks last on measures of health equity compared to other industrialized countries.

Health inequity is a multiple-industry issue with significant impacts (health, social, economic, etc.) on people and communities. Racial health disparities alone are projected to cost health insurers $337 billion between 2009 and 2018.

Healthcare organizations are increasingly making health equity a strategic priority, with varying degrees of success.

How can we tell if health equity has been achieved? “When everyone has the opportunity to attain full health potential, and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance,” according to a Robert Wood Johnson Foundation (RWJF)-commissioned *Communities in Action: Pathways to Health Equity* report (a year-long analysis by a 19-member committee of experts in national public health, healthcare, civil rights, social science, education, research, and business).

Many healthcare organizations, such as Allina Health, have initiated efforts to improve health equity by making it a systemwide strategic priority and investing in the right resources, infrastructure, and programs, which we’ll outline in this article. Other systems, however, are still largely unaware of the inequities and disparities within their walls.

Healthcare has a long way to go to effectively address health inequity, but there are evidence-based approaches to start tackling—or continue the battle against—health inequities. This article explores approaches, both simple and complex, health systems can implement to work toward restoring health equity.

Health Inequities and Disparities: Understanding the Problem

Why are racial and ethnic minorities in the U.S. disproportionately affected by poor quality of healthcare? Why are African American infants 3.2 times as likely to die from complications related to low birthweight than non-Hispanic white infants? Why is there a 25-year difference in life expectancy for babies who live just a few miles apart from each other in New Orleans (Figure 1)?

Figure 1: Life expectancy of babies varies by neighborhood in New Orleans

We can start to answer these questions by understanding what causes health inequity, as described in RWJF's *Communities in Action* report:

1. Intrapersonal, interpersonal, institutional, and systemic mechanisms (i.e., structural inequities) that organize the distribution of power and resources differently across lines of race, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identify.
2. Unequal allocation of power and resources—including goods, services, and societal attention—which manifests itself in unequal social, economic, and environmental conditions (i.e., determinants of health).

Health inequities are the result of more than individual choice or random occurrence; they are the result of poverty, structural racism, and discrimination. Health systems are just one cog in the wheel of the health inequity issue, but the role they play in the problem is a big one.

Healthcare's Role in Disparities

Looking at race- and ethnicity-related disparities, for example, differences in access to care, receipt of needed medical care, and receipt of life-saving technologies for certain populations "may be the result of system-level factors or may be due to individual physician behavior" according to an NCBI article. The article states that "patient race/ethnicity has been shown to influence physician interpretation of patients' complaints and, ultimately, clinical decision making."

The literature shows that clinicians have biases toward certain populations that impede their ability to provide effective care. Over time, these biases become institutionalized and harder to eliminate. Given that the perceived quality of healthcare (or lack thereof) can significantly impact health outcomes (e.g., adherence to medical advice, cancer screening recommendations, and medication regiments), many health systems find themselves in a self-perpetuating cycle of health inequities and poor health outcomes. Health systems exacerbate their health inequity problems when they don't have the required data (e.g., socioeconomic) or healthcare delivery structure to discover and correct disparities.

Given that health disparities are shaped by multiple determinants of health (social, economic, environmental, structural, etc.), achieving health equity requires engagement from not just healthcare, but also education, transportation, housing, planning, public health, and many other industries and businesses. Achieving health equity is a communitywide effort.

How to Make Health Equity a Strategic Priority

IHI says "health care professionals can—and should—play a major role in seeking to improve health outcomes for disadvantaged populations." Healthcare organizations committed to outcomes improvement must also be committed to health equity, and their first step is making it a systemwide, leadership-driven priority.

The *Health Equity Must Be a Strategic Priority* article outlines five ways health systems can make health equity a core strategy:

1. Make health equity a leader-driven priority (healthcare leaders must articulate, act on, and build the vision into all decisions).
2. Develop structures and processes that support equity (health systems must dedicate resources and establish a governance

structure to oversee the health equity work).
3. Take specific actions that address the social determinants of health (health systems must identify their health disparities and the needs and assets of people who face disparities, and then act to close the gaps). Some patient populations need additional support to achieve the same health outcomes as other patient populations (e.g., they need someone to drive them to appointments, they need home visits, etc.).
4. Confront institutional racism within the organization (health systems must identify, address, and dismantle the structures, policies, and norms that perpetuate race-based advantage).
5. Partner with community organizations.

Making health equity a strategic priority is the first step. Next, healthcare organizations need to tackle the disparities with proven interventions designed for their disadvantaged populations. The RWJF outlines specific steps health systems can take to address disparities:

> Adopt new vital signs to screen for the nonmedical factors influencing health.
>
> Commit to helping low-income and non-English-speaking patients get the care they need.
>
> Guard against the potential for bias to influence medical care.
>
> Make sure elderly, women, and racial/ethnic minorities are adequately represented in clinical trials.
>
> Understand the effects of adverse childhood experiences and use trauma-informed care.

Address the Socioeconomic Determinants of Health

Let's take a closer look at how health systems can incorporate nonmedical vital signs into their health assessment processes to paint a more detailed picture of their patients' health. RWJF's *Time to*

Act: Investing in the Health of Our Children and Communities report states that adding nonmedical vital signs (employment, education, food insecurity, safe housing, exposure to discrimination or violence, etc.) to existing ones (heart rate, blood pressure, weight, etc.) can help clinicians make better-informed decisions about treatment and care.

The article notes that new vital signs should be objective, readily comparable to population-level data, and actionable.

Adding nonmedical vital signs to health assessments facilitates healthcare and community collaboration by prompting patient referrals to community resources and improving clinician understanding of patients' lives outside of the hospital or clinic. It's this blurring of the lines between health systems and community organizations that will ultimately bridge the health inequity gap.

Health System-Community Collaboration Is Critical

A recurring theme in recommendations to improve health equity is community collaboration. One organization tackling health inequity with a community-based mindset is Health Share of Oregon, a local coordinated care organization (CCO) serving more than 240,000 Oregon Health Plan members. Its community-based approach connects its members with the services they need to be healthy:

- Training and education
- Support groups
- Care coordination
- Home improvement (i.e., home environment items, such as air conditioning or athletic shoes to improve mobility, access, hygiene, etc.)
- Transportation

Community health programs (e.g., farmers markets in food deserts)

Housing supports (e.g., shelter, utilities, and critical repairs)

Resource assistance (e.g., referral to job training or social services)

Other services that address social determinants of health (e.g., cell phones, gift cards to purchase supplies, etc.)

Health Share's *The Power of Together: Five Years of Health Transformation, 2012-2017* report details its health equity progress and how its "local communities come together to improve the health and health outcomes of Oregon Health Plan members, while simultaneously contributing cost savings to the system." Another health system, Allina Health, is also working to restore health equity for its underserved patients.

How One Health System Is Tackling Health Inequity—And Achieving Results

Illness, disability, and death are more prevalent and more severe for minority groups in the U.S., and Minnesota is no exception to this problematic trend:

In Minnesota, African-American and American Indian babies die in the first year of life at twice the rate of white babies.

In Minnesota, the rate of HIV/AIDS among African-born persons is nearly 16 times higher than among white, non-Hispanic persons.

In 2011, Minnesota started requiring healthcare providers to collect race, ethnicity, and language (REAL) data. The inequities revealed by this data motivated Allina Health, a not-for-profit healthcare system

serving communities throughout Minnesota and western Wisconsin, to take targeted actions to reduce inequities for some of its racial/ethnic minority patient populations.

Allina Health's approach to tackling its health inequities involved analytics, research, and targeted interventions. Allina Health used analytics to identify opportunities to reduce inequities, including improving colorectal cancer screening rates among its minority populations. Allina Health recognized that, despite having REAL data, its understanding of patient needs and perceptions regarding colorectal cancer screening was incomplete.

To complete the picture of its patients' health, Allina Health conducted research and focus groups to understand values, beliefs, and barriers impeding certain patient populations from completing the recommended colorectal cancer (CRC) screenings (e.g., concerns about discomfort with the procedure, based on prior healthcare experiences in a patient's home country where pain medication wasn't used, a lack of familiarity with the word screening, basic needs, such as food, housing, and bills, may take priority over preventive health treatment).

With an improved understanding of its patients' health beliefs and needs, Allina Health developed targeted interventions:

- Mails patients home testing/screening kits.
- Uses culturally tailored education materials, instructions, and FAQ documents written in the patient's primary language.
- Allina Health-employed care guides connect with patients to address barriers, including non-medical challenges (e.g., lack of transportation), to increase patient understanding of screening goals and options.
- Harnesses the power of community (e.g., social media campaigns that better engage African-American and Spanish-speaking patients).

Uses analytics to monitor effectiveness of interventions on populations at highest risk for poorest screening rates.

Allina Health's data-driven approach to reducing health inequities is beginning to make a difference: it has achieved a three percent relative improvement in CRC screening rates for targeted populations. And with REAL data embedded in its dashboards and workflow, it can identify and address additional disparities. Allina Health is one of many health systems making progress toward health equity by making it a strategic priority and implementing evidence-based, analytics-driven, community-informed, targeted interventions.

Beyond Patient Outcomes: Broadening Equity's Scope

Healthcare organizations can broaden equity's scope to include more than the health outcomes of the patients they serve; they can use their resources and status as employers to address equity in myriad other ways:

Develop a diverse workforce by improving hiring practices.

Provide training and growth opportunities for all employees:

- Train employees to ensure they can provide culturally and linguistically appropriate care.
- Train employees to support their career growth.
- Provide pathways and financial support for employees in entry level positions so they can progress to higher wage positions (nursing, administration, etc.).

Pay employees living wages:

Healthcare is a major economic force and many healthcare organizations are the largest employers in their

communities. Healthcare organizations can positively impact health equity by paying its employees living wages. Across the country, 70 percent of service workers employed by hospitals are paid less than $15 an hour. Most of these service jobs are held by minorities and women. Paying low wages to these groups perpetuates income inequality.

Build facilities in underserved communities:

Many healthcare organizations have moved out of poor neighborhoods to capture market share, increasingly building new hospitals in more affluent areas. These organizations can positively impact health inequity by building in deprived areas, making healthcare available to underserved patient populations.

Use a diverse pool of contractors and suppliers:

Supplier diversity efforts can positively improve the economic health of communities. Kaiser Permanente's supplier diversity initiative provides minority-owned, women-owned, veteran-owned, and small businesses the opportunity to participate in contracting and subcontracting activities. With the goal of spending $1 billion on goods and services, Kaiser Permanente fuels the economic growth of its communities, providing training internally and externally, attending and promoting supplier outreach events, and researching opportunities to engage diverse suppliers.

Henry Ford Health System's supplier diversity process includes more than 300 active minority- and women-owned businesses. Its transparent sourcing policy requires that all bids for more than $20,000 include one or more women- or minority-owned firms in the bid process (when available). The request for proposals process includes preference points for certified women- or minority-owned business and those that have supplier diversity processes in place.

Make healthcare investments beyond the required community

benefit and invest back into the community:

- Provide monetary support to increase the number of community spaces (e.g., parks, walkable trails, etc.).
- Invest in high school education programs that prepare students for healthcare careers and provide them with high school and college credit. Higher education translates to higher wages.

Achieving Health Equity is a Collaborative Effort and Industrywide Imperative

Success in healthcare requires organizations to improve quality and clinical effectiveness while decreasing costs. Healthcare organizations must include health equity as a strategic priority, broaden health equity's scope, invest in the structures and processes that improve health equity, and dismantle institutionalized racism.

In pursuit of health equity, organizations must also provide culturally competent care to many different patient populations who need clinicians to understand their lives, address their population-specific healthcare needs, change practices to be inclusive, collect data in a non-judgmental way, and build trusting relationships that enable them to openly participate in care—improvement strategies that are driven by a commitment to health equity.

Although the systemic root causes of health inequities and disparities in the U.S. will take time and hard work to eliminate, health systems can start now by making health equity a strategic priority championed by C-suites. Systems can tackle their data-exposed inequities with interventions of varying degrees of complexity, from adding nonmedical vital signs (e.g., employment) to health assessments, to forging and fostering community partnerships.

The statistics speak for themselves: U.S. Healthcare isn't equitable. Health systems must act promptly and strategically to remedy this nationwide underperformance and demonstrate their commitment to not only health equity, but also healthcare quality and outcomes improvement.

Additional Reading

Would you like to learn more about this topic? Here are some articles we suggest:

1. Advancing Health Equity – Data Driven Strategies Reduce Health Inequities
2. How Texas Children's Turned Child Diabetes Management into a Community Cause
3. Diversity in the Workplace: A Principle-Driven Approach to Broadening the Talent Pool
4. Population Health in Three Paragraphs (Executive Report)
5. Population Health Management: One Example That Shows Why It Really Matters

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Powerpoint Slides

Would you like to use or share these concepts? Download this presentation highlighting the key main points.

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Advancing Health Equity – Data Driven Strategies Reduce Health Inequities

December 12, 2017 | Posted in Enterprise Data Warehouse / Data Operating System , Patient Engagement , Population Health and Quality & Process Improvements .

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"We've learned that there is a difference between equality—where everyone is treated the same—and equity; providing our patients the level of support they need to be successful. By providing additional support to address the barriers, we are able to reduce health inequities."

– Jana Beckering, RN
Project Manager
Allina Hospitals and Clinics

EXECUTIVE SUMMARY

Health equity means that everyone has an equal opportunity to live the healthiest life possible – this requires removing obstacles to health. The U.S. ranks last on nearly all measures of equity, as indicated by its large, disparities in health outcomes. Illness, disability, and death in the United States are more prevalent and more severe for minority groups. Health inequities persist in Minnesota as well, which motivated Allina Health to take targeted actions to reduce inequities.

Allina Health needed actionable data to identify disparities and to reduce these inequities. This came in the form of REAL (race, ethnicity, and language) data, which Allina Health analysts used to visualize how health outcomes vary by demographic characteristics

including race, ethnicity, and language. To understand the root causes of specific disparities as well as to identify solutions within their sphere of influence as a healthcare delivery system, Allina Health consulted the literature and also consulted patients, employees and community members. Then Allina Health created appropriate interventions based on this information.

As a result, Allina Health created an awareness of the health inequities among its patient populations, as well as effective approaches to breach the barriers that were preventing these patients from getting the care they needed. While much work remains in this long journey to achieve health equity, Allina Health has taken some significant steps forward, including:

- Three percent relative improvement in colorectal cancer (CRC) screening rates for targeted populations, exceeding national CRC screening rates by more than ten percentage points.
- REAL data embedded in dashboards and workflow to easily identify and monitor disparities.

HEALTH INEQUITIES EXIST ACROSS THE U.S.

According to the Robert Wood Johnson Foundation, “Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”[1]

The U.S. ranks last on nearly all measures of equity because of its large income-related differences in health outcomes.[2] The most common causes of illness, disability, and death in the U.S.—heart disease, cancer, diabetes, and stroke—are more common and more severe for minority groups.

Health inequities persist in Minnesota as well, despite the efforts of many organizations and programs to improve health.[3]

African-American and American Indian babies die in the first year of life at twice the rate of white babies.

While infant mortality rates for all groups have declined, the inequity in rates has existed for over 20 years.

The rate of HIV/AIDS among African-born persons is nearly 16 times higher than among white, non-Hispanic persons.

American Indian, Hispanic/Latino, and African-American youth have the highest rates of obesity, and African-American and Hispanic/Latino women in Minnesota are more likely to be diagnosed with later-stage breast cancer.

Allina Health, a not-for-profit healthcare system with 12 hospitals and 67 clinic sites and ambulatory care centers, is dedicated to the prevention and treatment of illness, and helping people live healthier lives in communities throughout Minnesota and western Wisconsin.

HEALTH EQUITY PROBLEMS PERSIST IN MINNESOTA

For more than 15 years, Minnesota has tracked disparities in populations of color, American Indians, children, adolescents, immigrants and refugees, and lesbian, gay, bisexual, transgender, and queer (LGBTQ).

In 2011, the state of Minnesota began requiring healthcare providers to collect race, ethnicity, and language (REAL) data. These data revealed inequity. Available literature provided insight into several variables that contribute to these inequities:

Health system issues related to the complexity of the system,

how it has been poorly adapted to minority patients or those with limited English proficiency, and how it has been disproportionately difficult to navigate.

Care process issues related to care providers, including stereotyping, the impact of race and ethnicity on decision making, and clinical uncertainty due to poor communication.

Patient-related issues including patient's mistrust, poor adherence to treatment, and delays in seeking care.

Allina Health began stratifying some of its clinical quality outcomes metrics in 2013, revealing opportunities to close the gap amongst some of its racial/ethnic minority patient populations. This stratified data demonstrated that serious health inequities persisted, motivating Allina Health to take targeted actions to reduce inequities.

UNDERSTANDING CAUSES OF INEQUITY ENABLED CUSTOMIZED INTERVENTIONS

Using data to identify inequities

To be successful in reducing inequities, Allina Health needed to understand the outcomes its patients were experiencing. For this, it needed data. Using the Health Catalyst® Analytics Platform, including the Late-Binding™ Data Warehouse and a broad suite of analytics applications, Allina Health studied REAL data, and data regarding country of origin, to begin understanding inequities.

After standardizing data collection, categories of data, and methods used to conduct the analyses, data analysts at Allina Health provided visualizations of health outcomes by race, ethnicity, and language, and displayed the outcomes compared to the white, non-Hispanic/Latino, English-speaking population (see Figure 1).

Analytics revealed that Allina Health had opportunities to reduce health inequities, including improving colorectal cancer screening (CRC) rates. Allina Health developed a multi-level work plan to increase CRC screening rates among speakers of Somali, Hmong, Spanish, Arabic, and Russian languages; as well as Hispanic/Latino, American Indian, African-American, and Native Hawaiian and other Pacific Islander populations. The goal was to achieve a screening rate comparable to the white, non-Hispanic/Latino, English-speaking patients, incrementally closing the gap.

Allina Health recognized that despite having REAL data, its understanding of patients' needs and perceptions regarding CRC screening was likely incomplete. The REAL data, and data in the EHR, does not include important data regarding other factors that influence health, such as patient values and beliefs about healthcare and specific healthcare interventions, housing stability, financial resource strain, culture, gender identity, food insecurity, social connectedness, and other social determinants of health.

Figure 1. Sample health equity data – REAL data and comparison population.

Using literature and engagement to understand disparities

To develop a complete picture and understand root causes contributing to lower CRC screening rates, Allina Health researched available evidence about how to increase screening rates in minority populations, which increased its understanding of barriers, and activities to remedy those barriers.

Allina Health used focus groups with its certified medical interpreters, to gain additional understanding of various patient populations. Allina Health learned about values, beliefs, and barriers

that might impede patients from completing the recommended CRC screening:

- The subject matter may be perceived as shameful or sexual by some.
- Screening may be an unfamiliar concept. In some cultures, the word “screening” simply doesn’t exist. Phrases such as “looking for cancer” may be more effective.
- Concerns regarding discomfort with the procedure, based on prior healthcare experiences in a patient’s home country where pain medication was not used.
- Basic needs—food, housing, bills—may take priority over preventive health treatment.
- Discomfort with opposite sex providers and interpreters.
- Belief that cancer is God’s will, and that people should not intervene or try to prevent it.

Intervening and monitoring the effectiveness of interventions

With improved understanding of the needs of the various patient populations, Allina Health developed and implemented a work plan to improve CRC screening rates, which includes the following interventions:

- The health system mails patients home testing/screening kits. The health system uses culturally tailored education materials, instructions, and frequently asked question documents, all written in the patient’s primary language.
- Patients who do not complete the CRC screening after the initial offering receive a second kit and a phone call in their own language to remind them to complete the test. To convey the

benefit of completing the CRC screening, and to address questions a patient might have about the test.

Care guides employed by Allina Health connect with patients and work through barriers, including non-medical health related social needs and transportation needs, to increase the patient's understanding of screening goals and screening options. Allina Health harnesses the power of community, such as running colorectal cancer screening social media campaigns designed to better engage African-American and Spanish-speaking patients, a colorectal cancer screening video for Somali patients, and a skills-based employee-volunteerism campaign that invites Allina Health employees to talk to their social networks about the why and how to get screened for colorectal cancer. The social media campaigns and videos use evidence-informed communication to most effectively reach the community of interest. Allina Health also its website to communicate the importance of CRC screening and is investigating the use of newspaper, radio, and television.

Through its analytics application, Allina Health is able to monitor the effectiveness of its interventions on the populations at highest risk for the poorest screening rates (see Figure 2).

Figure 2. CRC screening rate among white/Non-Hispanic/Latino, English-speaking patients compared to CRC screening rate among black or African-American patients.

RESEARCH AND DATA-DRIVEN RESULTS

Allina Health's data-driven approach to reducing health inequities demonstrated effectiveness through customized interventions. The system increased its understanding of health equity, improved its awareness of where inequities existed, and confirmed an effective approach for reducing them resulting in:

Three percent relative improvement in colorectal cancer (CRC) screening rates for targeted populations, exceeding national CRC screening rates by more than ten percentage points.

REAL data embedded in dashboards and workflow to easily identify and address disparities.

WHAT'S NEXT

The integration of demographic filters into all of Allina Health dashboards has enabled the organization to identify opportunities to address health inequities in many areas, including:

Primary care—diabetes, hypertension, asthma, pediatric immunizations, cancer screening, no show-rates, primary care provider assignment.

Obstetric care—breastfeeding, transfusion, post-partum hemorrhage, pre-term delivery, fetal loss.

Mental health—depression screening, depression claims, outpatient follow-up.

Emergency care—ED utilization, wait times, use of restraints/seclusions.

Hospital care—potentially avoidable hospitalizations for diabetes, HF, asthma, COPD, pneumonia and depression, readmissions, high-tech imaging claims.

Pharmacy utilization.

The organization will continue to build capacity for the organizationto understand the root causes of the inequities and to take action. Allina Health is sharing the learnings from this important work and creating additional organizational capacity to reduce health inequities throughout the organization, integrating health equity data into all its quality improvement efforts.

REFERENCES

1. Braverman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017). What is health equity: And what difference does a definition make? *Robert Wood Johnson Foundation.* Retrieved from https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html
2. National Quality Forum. (2008). *Closing the disparities gap in health quality with performance measurement and public reporting.* Retrieved from http://www.qualityforum.org/Publications/2008/08/Closing_the_Dispa in_Healthcare_Quality_With_Performance_Measurement_and_Public_
3. Minnesota Department of Health, Commissioner's Office. (2014). *Advancing health equity in Minnesota: Report to the legislature.* Retrieved from http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_

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