Project Lead/Key Contact
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Why are you interested in the Improvement Scholars Program?
Participating in the Improvement Scholars Program (ISP) aligns strongly with my commitment to advancing patient care and promoting health equity, particularly for patients with limited English proficiency (LEP). The program offers a unique platform for multidisciplinary collaboration, connecting professionals from diverse backgrounds to develop and implement targeted solutions to healthcare disparities. The comprehensive quality improvement (QI) training will enhance my expertise in QI methodologies, teamwork, and leadership, enabling me to contribute more effectively to our institution's ongoing initiatives. As a junior faculty member, this program represents a critical step in my professional growth, preparing me to lead impactful QI projects that improve the quality of care and outcomes for our patients.

Problem Statement: What is the problem you are looking to solve?
Language barriers represent a significant health disparity for patients with LEP, adversely affecting access to healthcare, comprehension of medical information, informed decision-making, and ultimately patient outcomes. At the University of North Carolina Medical Center (UNCMC), this disparity disproportionately impacts adult Spanish-speaking inpatients, which made up ~12% of patients at UNCMC in fiscal year 2021.[1] Inaccurate assessment and documentation of language needs in the electronic medical record (EMR) further exacerbate these barriers by hindering the consistent and appropriate use of medical interpreters, thus compromising patient care quality. A retrospective analysis conducted at UNCMC demonstrated clear clinical consequences associated with language barriers: Spanish-speaking patients exhibited significantly greater disease severity at the time of rapid response (RR) system activation (OR = 1.82, p = 0.021) and experienced an 18.5% longer hospital stay post-RR events compared to primarily English-speaking patients (95% CI = 3.2–36.1, p = 0.016).[2] Although subsequent QI initiatives involving systematic prioritization of patients with LEP and integration of interpreters into RR teams successfully reduced monthly mortality rates among adult inpatients with LEP from 7.42% to 6.09%, the effectiveness of these efforts remains limited by inaccuracies in identification and documentation of language needs.[3] Further investigation at our institution underscored the magnitude of this documentation problem: a mixed-method study of 156 adult Spanish-speaking inpatients identified with discrepancies including missing documentation (22%) and direct contradictions (9.92%) between EMR documentation and patients' self-reported interpreter needs. These findings align with existing literature on challenges with EMR documentation of race, ethnicity, and language (REaL) data.[4,5] Inaccurate REaL data documentation can worsen healthcare disparities by failing to properly identify and then address the needs of minority patients.[6,7] These studies reveal a concerning current reality where language barriers continue to be a major obstacle for patients with LEP at our institution. This project will address the critical gap in accurately assessing and documenting language needs in the EMR for adult inpatients at UNCMC. By implementing a standardized language screening tool coupled with a validated language proficiency assessment protocol (the Short Assessment of Health Literacy – SAHL) for Spanish-speaking patients identified as having moderate or high likelihood of undetected LEP, we aim to improve the accuracy of language data. This initiative will facilitate appropriate interpreter utilization, promote health equity, and ultimately enhance the quality of care and outcomes for our patients.

Importance Statement: Why is this project important?
Accurate identification and documentation of patients' language needs in the EMR, accompanied by appropriate language access services, are both ethical responsibilities and legal mandates under Title VI of the 1964 Civil Rights Act. This project directly aligns with UNC Health's organizational priorities of promoting health equity,

patient safety, and high-quality care, as well as the Joint Commission's hospital accreditation requirements aimed at reducing healthcare disparities.

Effective communication is foundational to patient-centered care. When language needs are not accurately captured, patients with LEP face increased risk of harm due to miscommunication, delays in diagnosis or treatment, and unmet care needs. These gaps disproportionately affect Spanish-speaking patients at UNCMC and contribute to broader inequities in health outcomes. Addressing this problem not only promotes compliance with regulatory standards but also advances our institution's commitment to health equity.

Existing evidence from successful interventions at other institutions underscores the value of accurate documentation of race, ethnicity, and language (REaL) data.[4,8-14] For example, a previous study demonstrated that the introduction of a screening question, an emergency department track board language icon, and an EMR alert for how to request interpreter services significantly increased LEP patient identification rates, interpreter utilization, and interpreter documentation by up to 35%.[4] Implementing similar strategies at UNCMC is anticipated to similarly enhance care quality and safety for our diverse patient population.

Improving the accuracy of EMR language data will support equitable care delivery, reduce preventable adverse events, and build trust in the healthcare system. It will also strengthen the quality of institutional data used for quality improvement, risk adjustment, and disparities monitoring. By embedding inclusive communication practices into clinical workflows, this project will help ensure that every patient—regardless of language— receives safe, informed, and dignified care. Ultimately, through accurate identification, thoughtful intervention, and inclusive communication strategies, this project will substantially enhance the quality of care, health equity, and patient outcomes at UNCMC.

Project Scope

In Scope: This project targets adult inpatients at UNCMC, specifically Spanish-speaking patients who have a moderate to high likelihood of LEP. UNCMC is located in Chapel Hill, NC, where 6.8% of residents identify as Hispanic or Latino, 15.8% of the population is foreign-born, and 20.3% of households speak a language other than English.[15] Compared to the statewide hospital inpatient population, UNCMC inpatients are more than twice as likely (2.05x) to be Hispanic.[16] Furthermore, in 2022, the U.S. Census Bureau reported that 21.7% of respondents spoke a language other than English at home, 8.2% spoke English less than "very well," and 13.3% spoke Spanish at home.[17]

The intervention will be piloted on the 1 Memorial Observation Unit, selected for its high patient turnover rate and potential for broad reach. Upon admission, all adult patients will complete a brief language screening questionnaire. Spanish-speaking patients scoring at moderate or high likelihood of LEP will undergo a comprehensive language proficiency assessment (the SAHL) with the help of a Certified Medical Interpreter. Based on current census estimates, we anticipate this intervention will affect several patients daily.

Out of Scope: The initial pilot will not include patients in other inpatient units, those seen in outpatient or non-clinical settings, or those who speak languages other than Spanish. Pediatric patients and individuals unable to complete the screening or assessment due to critical illness or cognitive impairment will also be excluded.

The long-term goal is to expand this initiative across all adult inpatient units and to patients who speak other languages. Lessons learned during the pilot will guide broader implementation and inform a sustainable, inclusive language equity strategy for the medical center.

Measures: (Process, Balancing, Structure)

Accurate and meaningful measurement is essential to achieving our goal. To monitor our progress, we will use run charts and control charts to track process, outcome, and balancing measures, as outlined in the below table.

Measure Name	Measure Type	Measure Calculation	Measure Exclusion	Data Source	Baseline	Goal	Collection Frequency
LEP screening completion rate	Process	Number of eligible patients who receive initial language screening ÷ total number of eligible admissions	Patients not meeting inclusion criteria or meeting exclusion criteria	EMR	Not currently measured	≥ 80%	Monthly
Language proficiency assessment rate for Spanish-speaking patients who screen positive for moderate/high LEP risk	Process	Number who screen positive and complete SAHL assessment ÷ total number of patients who screen positive	Patients not meeting inclusion criteria or meeting exclusion criteria	EMR / Interpreter Services Logs	Not currently measured	≥ 90%	Monthly
Interpreter use rate for identified Spanish-speaking LEP patients	Process	Number of distinct patients who received at least one interpreter encounter ÷ total number of patients identified via language assessment screening	Patients who decline interpreter services	EMR / Interpreter Service Logs	Estimated at <60%	≥ 70%	Monthly
Pre- versus post-intervention 30-day readmission rate for Spanish-speaking LEP patients	Outcome	Number of patients readmitted within 30 days ÷ total number of discharges	Patients discharged to hospice or transferred to another facility	EMR	To be established	Decrease from baseline	Quarterly
Pre- versus post-intervention mortality rate for Spanish-	Outcome	Number of patients who die ÷ number of patients	Patients not identified on the screener	EMR	For 1 Memorial Observation Unit between	Decrease from baseline	Quarterly

speaking LEP patients		admitted to the unit			1/1/2023 to 1/1/2025, patients who had a language listed as "Spanish" the average mortality rate was 0.3% and the average mortality index was 0.28.		
Staff and patient perception of communication effectiveness for Spanish-speaking LEP patients	Outcome	Staff- and patient-reported experience with the language screening and assessment tools and communication with patients and their families	Staff and patients not on pilot units	Staff survey	Not currently collected	>85% positive responses	Monthly (pilot), then quarterly
Pre- and post-intervention unit admission intake time	Balancing	Average time to complete admission intake documentation (difference between admission intake form opened and closed)	None	EMR	Baseline to be collected	No increase from baseline	Monthly

Root Cause Analysis

The inaccurate assessment and documentation of patient language proficiency in the EMR arises from several interconnected factors. Current methods used to evaluate language proficiency and interpreter needs are outdated and insufficiently precise, failing to capture the complexities of patient communication within healthcare contexts. Although inaccuracies in EMR language data have been recognized as problematic since at least 2010, many institutions continue to rely on overly simplistic screening processes.[18] Terms such as "limited English proficiency" do not fully represent the nuanced language requirements of patients who might speak conversational English but still need interpreter assistance for complex medical interactions.[19-22] At our institution specifically, data indicates that 30.13% of Hispanic inpatients experience discrepancies between EMR-documented and self-reported interpreter needs, underscoring the persistence and severity of this issue. This mirrors prior studies documenting the broader challenges of accurate REaL data capture.[6,23]

Additionally, reliance on patient self-assessment for determining language proficiency and interpreter needs is inherently flawed. Patients frequently underreport their interpreter needs due to factors such as fear, embarrassment, or cultural influences. Conversely, healthcare providers often overestimate their own ability to effectively communicate without interpreters, further complicating accurate assessments.[24-26]

Systemic issues also significantly contribute to this problem. Many healthcare institutions lack standardized, validated protocols for accurately recording patient language and interpreter requirements. Staff frequently do not receive adequate training in assessing and documenting language proficiency, further perpetuating inaccuracies within EMR systems and negatively affecting the quality of patient care.[6,18,20,27]

Moreover, poor documentation directly results in insufficient use of interpreter services. When patient language needs are inaccurately recorded, it becomes less likely that necessary interpreter support will be provided, thus exacerbating health disparities. Conversely, institutions that have successfully implemented improved EMR documentation practices have seen increased interpreter utilization and consequently, more equitable care outcomes.[13,19,23,28,29]

Ultimately, the inaccurate documentation of patient language proficiency in EMRs stems from outdated assessment practices, reliance on problematic self-reporting methods, provider misjudgments, and systemic gaps in training and standardization. Addressing these underlying factors is essential for enhancing patient-provider communication and advancing equitable healthcare for patients facing language barriers.

Ideas for Improvement

To address the root causes of inaccurate language proficiency assessment and EMR mischaracterization of language needs, we propose a multifaceted intervention aimed at improving data accuracy, provider awareness, and access to language-concordant care.

To begin, we first propose a two-tiered intervention. The first tier involves implementation of a brief 1-3 question screening tool—adapted from the American Community Survey—administered at intake and designed to identify Spanish-speaking patients at moderate or high likelihood of LEP. Patients meeting this threshold will then undergo a second-tier, 5-minute comprehensive language proficiency assessment—adapted from the validated Short Assessment of Health Literacy (SAHL)—conducted by a Certified Medical Interpreter. The results, particularly interpreter needs, will then be clearly and accurately documented in the EMR. This targeted, two-tiered approach improves specificity while minimizing burden on staff and patients. To ensure success, the process will be iteratively refined through PDSA cycles, with active feedback from frontline clinical team members. Their input on usability and impact will directly inform ongoing revisions to maximize feasibility and clinical integration.

Once the process is optimized, the intervention will be scaled across all adult inpatient units and eventually adapted for patients who speak other non-English languages. Integration with Registration Services is envisioned to embed screening earlier in the care process, minimize burden on bedside staff, and enhance sustainability. By embedding a structured, validated, and responsive process for language proficiency identification and documentation into daily clinical workflows, this intervention will significantly improve interpreter service utilization, reduce communication-related errors, and advance equity in care delivery for LEP patients.

We also recognize that tools and technology alone are insufficient without corresponding education and culture change. As part of this initiative, we will implement targeted staff training to familiarize clinical teams with the new screening tool, its rationale, and the interpreter services available. This will help build buy-in, address common misconceptions (e.g., provider overconfidence in cross-language communication), and foster a stronger culture of accountability for equitable care delivery.

Collectively, these changes will significantly improve the accuracy of EMR language data, facilitate timely and appropriate interpreter use, and promote more consistent delivery of language-concordant care. In doing so, we aim to reduce communication-related health disparities and ultimately improve outcomes, including patient satisfaction, adherence, and even mortality, among LEP populations.

Risks and Opportunities

Several key factors are expected to drive improvement in this project. Foremost is the strong partnership with institutional stakeholders, including Interpreter Services, Registration Services, House Supervisors, and unit Nurse Managers. These leaders bring critical operational insights and frontline experience that will guide practical implementation and promote buy-in across roles. Their active participation in monthly feedback meetings and ongoing engagement through staff and patient satisfaction surveys will create a dynamic feedback loop to iteratively refine the intervention.

Additionally, we anticipate that demonstrable improvements in communication, patient satisfaction, and safety for patients with LEP will generate intrinsic motivation for continued use among providers and further institutional support for system-wide scale-up. The project's alignment with broader goals of health equity and patient-centered care also increases the likelihood of organizational backing and long-term sustainability.

We anticipate three primary challenges:

1. <u>Increased staff burden</u>: Introducing additional screening steps during admission may raise concerns about workflow disruption. To mitigate this, the language screening and proficiency assessment processes have been selected specifically for the minimal time and effort required for administration (30-60 seconds and 5-minutes, respectively). We envision the latter can be conducted by a Certified Medical Interpreter during an existing clinical interaction to minimize additional burden.

2. <u>Risk of stigmatization</u>: Language proficiency testing may inadvertently contribute to patients feeling singled out or stigmatized. To address this, all language proficiency assessments will be conducted by culturally competent Certified Medical Interpreters using a standardized, empathetic script that clearly explains the assessment's purpose is solely to enhance their healthcare experience. Furthermore, patient and family satisfaction surveys will be employed to monitor for unintended consequences and guide improvements. We recognize patients may have inherent pushback to working with interpreters guided by misconceptions or prior negative experiences and we hope to address this as above, knowing some patients may still refuse.

3. <u>Clinical ineligibility for screening/assessment</u>: Some patients may be too acutely ill or cognitively impaired to complete the screening and assessment process. We have developed clear exclusion criteria to address this challenge, omitting patients with delirium, severe dementia, encephalopathy, or psychosis.

By proactively identifying these challenges and embedding solutions into our design, we aim to ensure a thoughtful, patient-centered approach that maximizes effectiveness while minimizing disruption and harm.

Stakeholders and Project Team Members

Key stakeholders include bedside nurses, physicians, registration staff, interpreter services, and most importantly, Spanish-speaking patients and their families. Their insights and engagement will shape implementation and sustainment. The core project team responsible for designing and implementing the intervention is listed below.

Name	Role
Nelly Bellamy, MD Division of Hospital Medicine	*Project Lead*
Charles Webster, CMI-Spanish Education Specialist, Interpreter Services	*Project Lead and Sponsor*
Lizzie Gottschalk, RN Patient Services Manager III - UNCH Observation Unit Main Campus	*Project Lead*
Danielle Ward, RN Patient Services Manager III - UNCH 7BT	*Project Lead*
Brandy Green, BSN RN CPN Nursing Staffing Systems - House Supervisors	*Project Lead*
Susan Good HCS Patient Access Manager	*Project Lead*
Anna Garofalo, RN Admission Nurse Manager	*Project Lead*
Lauren Raff, MD, FACS Division of General and Acute Care Surgery	*Subject Matter Expert*
Ricardo Crespo Regalado UNC School of Medicine	*Subject Matter Expert*
Emily C. Bulik-Sullivan UNC School of Medicine	*Subject Matter Expert*
Mary Jo Barfield UNCMC Office of Quality Excellence – Performance Improvement	*Data lead*
Carlton Moore, MD MS Associate Chief, Division of Hospital Medicine	*Project Sponsor*
Evan Raff, MD, FHM Division of Hospital Medicine	*Project Sponsor*

Impact on the Quintuple Aim

This proposal directly advances all five components of the UNCMC Quintuple Aim by addressing a foundational, yet under-recognized, driver of health disparities: language barriers in clinical care. Through implementation of a standardized, validated language screening and proficiency assessment protocol, this project ensures that interpreter services and related interventions reach Spanish-speaking inpatients with LEP accurately and efficiently, patients who would otherwise not have benefitted from the language resources UNC has to offer.

Improved health is supported by reducing communication-related errors and delays, enabling timely clinical decisions, and improving early identification of clinical deterioration. By building on existing UNCMC initiatives—such as proactive monitoring of patients with LEP, preemptive consultations with critical response nurses, targeted RR activations, and perioperative interpreter access—this project strengthens the effectiveness of these efforts by addressing the root problem: inconsistent and inaccurate documentation of language needs in the EMR. At the population health level, more accurate identification of LEP patients enables earlier interventions, prevents complications, and contributes to improved care quality across diverse patient groups. Moreover, enhanced EMR documentation will elevate the quality of REaL data used for institutional risk adjustment, disparities reporting, and strategic planning—laying the groundwork for health system-wide learning and equity-driven decision-making.

Health equity is the central aim of this work. By eliminating the inconsistencies and biases in how language needs are identified and recorded in the EMR, this project directly dismantles a structural barrier to equitable care. It operationalizes language access as a right, not a workaround, and ensures that all patients—regardless of English proficiency—receive safe, informed, and respectful care.

This project also significantly enhances the **patient experience** by promoting respectful, transparent, and language-concordant communication. Patients are empowered to participate in their care with clarity and confidence, fostering trust and satisfaction in their healthcare journey. This will further improve our patients' perception of UNC Health.

For providers, the intervention improves the **clinician and staff experience** by reducing the moral distress and inefficiencies caused by language discordance. By integrating interpreter needs directly into clinical workflows and improving data accuracy, the project supports team communication, operational ease, and delivery of care in busy hospital units. These changes contribute to higher staff engagement and satisfaction, reinforcing retention in an increasingly values-driven clinical workforce.

Finally, this initiative helps **reduce costs** by minimizing avoidable diagnostic testing, unnecessary consultations, prolonged hospital stays, and downstream complications that often stem from miscommunication. At the same time, it reinforces UNCMC's commitment to a high-reliability, patient-centered safety culture by targeting one of the most preventable sources of harm: communication failure.

This work positions UNCMC as a national leader in the equitable redesign of care delivery—demonstrating how health systems can operationalize language equity to improve outcomes for patients, providers, and the system.

Sustainment Plan

To ensure the long-term sustainment of this initiative, we will embed continuous feedback, iterative improvement, and institutional integration into the project's core design. Sustainment will be supported through ongoing collaboration with key interdisciplinary stakeholders—including interpreter services, registration services, nursing leadership, and quality and safety teams—via routine structured meetings. These meetings, along with regular patient, family, and staff satisfaction surveys, will inform continuous refinement through PDSA cycles. This model of active engagement and feedback ensures the intervention remains responsive to frontline realities, maximizes clinical relevance, and maintains alignment with evolving institutional priorities.

We envision that the infrastructure and insights developed through the ISP will serve as a springboard for broader institutional adoption. Once validated, the initial Spanish language screening and assessment process will be scaled across all adult inpatient units and ultimately adapted for patients who speak other languages. A key component of sustainment will be transitioning the initial language screening tool to registration services, embedding it as a standard part of the hospital intake process. This shift will institutionalize the assessment at the point of entry and ensure systematic identification of language needs without adding burden to clinical workflows. Additionally, language proficiency testing protocols will be developed for other high-prevalence non-English languages, further expanding the reach and equity of the intervention.

To support long-term viability, we will advocate for integration of the language screening data into existing EMR dashboards. This would allow interpreter service needs to be anticipated and allocated in real-time, improving both resource management and patient care. Ultimately, by aligning this initiative with existing workflows, data systems, and institutional goals—rather than adding parallel processes—we will ensure that the work begun with IHQI's support evolves into a sustainable, system-level strategy for advancing language equity and improving care delivery across UNCMC.

Carolina Quality Tools

Carolina Quality tools will be integral to embedding this project within UNCMC's culture of safety, teamwork, and continuous improvement. **Unit-based huddles** will serve as a primary mechanism for introducing and

reinforcing the language screening workflow, allowing staff to raise questions, share feedback, and troubleshoot challenges in real time. **SAFE reporting** will be promoted to capture language-related safety events and near misses involving Spanish-speaking patients, generating actionable data to guide further process improvements. **Just Culture** principles will frame responses to errors or documentation gaps, promoting learning and system-level accountability rather than individual blame. Additionally, **TeamSTEPPS** strategies, such as Situation, Background, Assessment, Recommendation (SBAR), will support clear communication of interpreter needs during handoffs and escalations, thereby reinforcing team coordination and consistent language services for patients with LEP.

Collectively, these tools will strengthen implementation, foster frontline engagement, and sustain a culture of equitable, patient-centered care.

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Laura Brown, MPH
Associate Vice President - Quality
UNC Medical Center
101 Manning Dr. Chapel Hill, NC 27514

April 9, 2025

Dear Improvement Scholars Program Grant Selection Committee:

This letter is to express my support of Dr. Nelly Bellamy and her team's proposed project to improve the assessment and documentation of patients' interpreter needs. This project aims to improve the quality of care for non-English speaking patients hospitalized at UNC Medical Center. As Associate Vice President, Quality, I recognize the importance of this initiative to address language-related disparities in healthcare.

The proposal outlines the current discrepancy between a patient's documented interpreter needs and their English language proficiency, which contributes to health disparities for patients with low English proficiency. The team intends to improve characterization of patients' language needs, leading to more equitable care. They propose implementing a screening tool and a language proficiency assessment in support of this aim. Accurately documenting the language needs of patients should result in increased interpreter use resulting in improved patient outcomes and quality of care. Dr. Bellamy is collaborating with Interpreter Services leaders and teammates, two nurse managers, the house supervisor manager, and Patient Access leaders.

I believe this initiative can improve the quality of care for patients at UNC Medical Center. I appreciate the dedication of the project team and look forward to witnessing the project's positive impact on patient care and outcomes.

Sincerely,

Laura Brown

Laura Brown, MPH
Associate Vice President - Quality
UNC Medical Center

Charles Webster
Interpreter Services
UNC Hospital
101 Manning Drive
CB# 7600
Chapel Hill, NC 27599
984-974-1926

April 9, 2025

Dear Improvement Scholars Program Grant Selection Committee:

I am writing to express my support for Dr. Bellamy's proposed language access project. As the Education Specialist of UNC Hospital's Interpreter Services, I am particularly enthusiastic about the positive impact this initiative will have on our patient care and outcomes.

Language barriers are a significant health disparity that negatively impact our patients. The project's focus on accurately characterizing language needs aligns seamlessly with our commitment to providing improved care. The development of a standardized language proficiency assessment method, integration into the EHR, and subsequent education for staff are crucial steps toward providing improved care to our diverse patient population. The emphasis on education and awareness among staff will enhance our ability to deliver culturally sensitive care and reduce patient harm and mortality.

As the **Education Specialist** of Interpreter Services, I am fully committed to supporting the successful implementation of this project. I believe this project will not only improve the quality of care we provide at UNC but also set a standard for improved language access in healthcare. Thank you for your attention to this matter, and I look forward to collaborating with the project team to ensure the seamless integration of these important changes into our workflow. On behalf of Interpeter Services and our patients, thank you in advance for your consideration of this project proposal.

Sincerely,

Charles D. Webster

Charles Webster, CMI-Spanish
Education Specialist, Interpreter Services
UNC Hospital

April 10, 2025

Dear IHQI ISP Admission Committee,

I am writing to express my unwavering support for the project proposed by Dr. Nelly Bellamy, which aims to enhance the identification of hospitalized patients with limited English proficiency (LEP). As a Professor and Associate Division Chief in the Division of Hospital Medicine, I have firsthand witnessed the challenges faced by LEP patients in accessing quality healthcare services during their hospitalizations.

Firstly, as a junior faculty member, Dr. Bellamy demonstrates a strong commitment to becoming a quality improvement leader at UNC Health. Her passion for acquiring quality improvement skillsets enables her to effectively address the quality of care we provide to hospitalized patients, with a specific focus on health equity and language barriers.

Effective communication is the cornerstone of patient safety and quality care. Patients with LEP often encounter significant barriers that can lead to misunderstandings, misdiagnoses, and inadequate treatment. This project is pivotal in addressing these issues by implementing systematic identification processes and protocols to ensure that LEP patients receive appropriate language assistance services.

The benefits of this project are far-reaching. By accurately identifying LEP patients, healthcare providers can promptly and effectively provide interpretation services, thereby enhancing patient comprehension, adherence to medical instructions, and overall satisfaction with care. Furthermore, this initiative aligns seamlessly with our commitment to health equity and the provision of culturally competent care.

I am confident that this project will lead to improved health outcomes for LEP patients and contribute to a more inclusive and responsive healthcare system. Dr. Bellamy is an exceptional candidate who is poised to lead quality improvement efforts at UNC Health. I wholeheartedly support her initiative and am willing to collaborate in any capacity to ensure its successful implementation.

Thank you for considering this significant project. Please do not hesitate to contact me if you require any further information or support.

Sincerely,

Carlton Moore

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