NAACOS 2022
Leaders in Quality Excellence Award

Agenda

- Overview of the Leaders in Quality Excellence Award
- ACO preparations:
  - Summit Health, Tabita Delisca
  - St. Joseph's Health, Jim Giordano
  - UNC Health Alliance, Matt Gitzinger
- Questions from the audience

2022 Leaders in Quality Excellence Award

- Established to recognize the outstanding efforts among ACOs working to improve the quality and safety of patient care and advance population health goals

- Selected by the NAACOS Quality Committee

- Criteria for submission:
  - The ACO must be a NAACOs member
  - The quality project must have taken place within in the last 1-3 years
  - There is no limit on the population targeted for the intervention and projects do not need to be tied to ACO program quality measures
  - Limit entries to one submission per ACO

Committee Members

- Megan Reyna (Chair) - Advocate Aurora Health (IL)
- Dr. Rob Fields (Past Chair)- Mount Sinai (NY)
- Dr. Bracken Babula- Jefferson Internal Medicine Associates (PA)
- Dr. Richard Feifer- Genesis Physician Services (PA)
- Adriana Quiroga-Garcia- Trinity Health, St. Josephs (NY)
- Dr. Yates Lennon- CHESS (NC)
- Dr. Daniel Hyman – All Care Health Alliance (NJ)
- Dr. Ashish Parikh – Summit Health (NJ)
- Lori Schultz – VillageMD (MI)
- Rayna Caplan- Caravan Health
- Dr. Aaron Clark- The Ohio State University Medical Center (OH)
- Dr. Josh Israel- Aledade Inc.
- Paula Burleson- Novant Health (NC)

2022 Award Recipients

- **Summit Health**
  - Presenter: Tabita Delisca, MSN, RN
    Tdelisca@summithealth.com

- **St. Joseph's Health**
  - Presenter: Jim Giordano
    Giordanoj@sjhmc.org

- **UNC Health Alliance**
  - Presenter: Matt Gitzinger, MHA, FACHE
    Matt.Gitzinger@unchealth.unc.edu

"All's Well That Ends Well"

AWV Rates and Ever Better Care & Outcomes

Tabita Delisca, RN, MSN, Senior Quality Improvement Specialist
Deborah A. Molina, MBA, MPA, Director of Quality
Rishita Bhatt, MPH, MBA, Director of Value Based Care
Jamie Reedy, MD, MPH, Chief Population Health Officer
Ashish D. Parikh, MD, Chief Quality Officer

Summit Health + CITYMD

Summit Health

340 locations across 5 states

New Jersey | New York | Oregon | Connecticut | Pennsylvania

2,500+ providers

12,000+ employees

30+ risk-based contracts

275K+ attributed patients

Building Healthier, Kinder Communities

TOGETHER

What We Did

Efforts

Implemented a **concerted, systematic effort** to increase completion rate and effectiveness of Medicare Annual Wellness Visits (AWVs)

Outcomes

AWV rates **increased** and remained high even during pandemic

Patients with an AWV had **higher**:

- Quality Gap Closure Rates
- Persistent ACO Attribution
- Disease Burden Capture

What You will Learn

- **Best practice used to increase the number & impact of AWVs at Summit.**
- **How to effectively implement a successful multi-faceted approach.**
    1. How to ensure buy-in from all stakeholders
    2. What process improvements were implemented & what investments are needed to ensure long-term & sustained benefits
    3. How to measure and report impact of efforts

Multi-Faceted Approach

Identify & Engage Stakeholders	+	Process Improvements, Needed Investments	+	Actionable Transparent Reporting
PCP Providers & Clinical Team		Quality Department		Analytics Team Reporting
Administrators and Leadership Teams		Coding compliance		Compensation Committee Oversight
Support Staff		Clinical Informatics		Inclusion in Provider Incentive Program
Patients		Marketing		Patient Level Detail

Stakeholders: Making AWV believers

- Educated on benefits of AWVs
- Created focused presentations and went on a “road show”:
  - **Primary care providers** and care teams
  - **Administrators** and leadership teams
  - **Support staff** (center members, marketing, EHR and patient relations teams)

Implemented Process improvements

- **Coding Compliance**: created “one pager” with key components needed to bill IPPEs, initial AWVs, and subsequent AWVs
- **Quality Department**: developed workflows to help clinical teams use pre-visit chart prep, close gaps, and collect needed information
- **Clinical informatics:** EHR AWV encounter template that reduced the click burden
- **Marketing:** socialized patient-facing materials on the benefits of AWVs for Medicare beneficiaries

Actionable, Transparent Reporting

- **Analytics team:** created recurring monthly report that shows PCPs their AWV completion rate along with a list of patients
  - are eligible now
  - will be eligible in coming months
  - already have a scheduled or completed AWV this calendar year

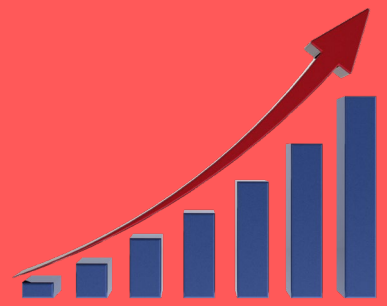
Provider	MRN	Patient Name	AWV Status	Last AWV Visit Date	Next AWV Visit Date	Next PCP Visit Date	Open RAF
PARIKH_A_MD	11111111	SMITH, JOHN	Not Satisfied	06/02/2021			0.858
PARIKH_A_MD	22222222	DOE, JANE	Not Satisfied	07/19/2021	07/21/2022		0.963

- **Compensation committee:** added AWV completion rates to the universal incentive program for IM/FM providers


IMPACT

Significant increase in YOY AWV rates

Achieved and sustained a high AWV completion rate, despite the pandemic over the past two years.

AWV Completion Rate 	2017	2018	2019	2020	2021
	39%	50%	71%	67%	72%

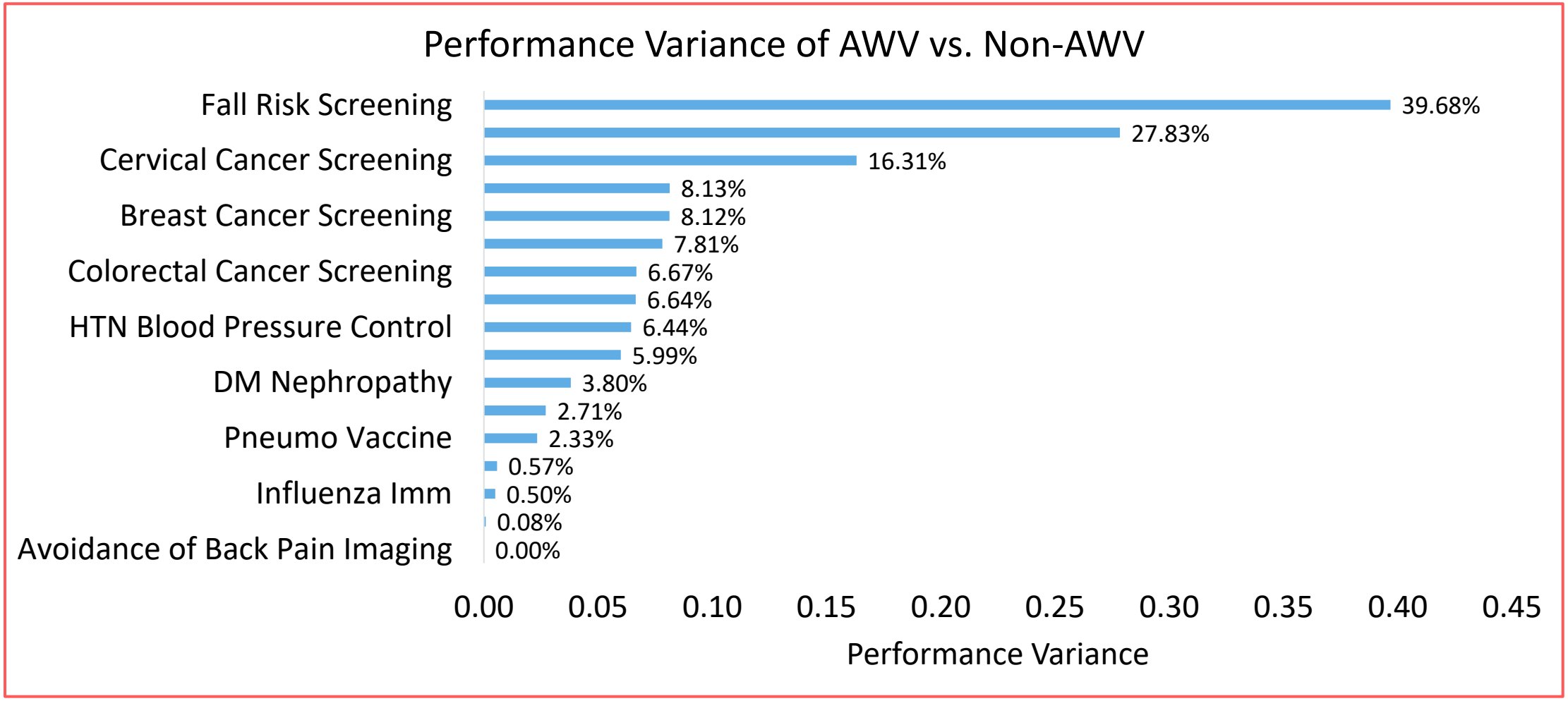
Improved Quality Measure Performance

Impact of AWVs, as part of a larger population health management strategy, seen in **progressive improvement preventive quality measure performance rates YOY**

QUALITY MEASURE	2017	2018	2019	2020
Breast Cancer Screening	73.60%	70.63%	74.68%	81.30%
Colorectal Cancer Screening	72.60%	85.92%	80.67%	81.39%
Fall Risk Screening	77.76%	92.02%	98.30%	97.90%
Tobacco Screening/Cessation	73.08%	75.00%	75.00%	100.00%
Influenza Vaccination	78.57%	87.41%	89.70%	91.14%

Patients with AWV

8% Higher Quality Measure Gap Closure

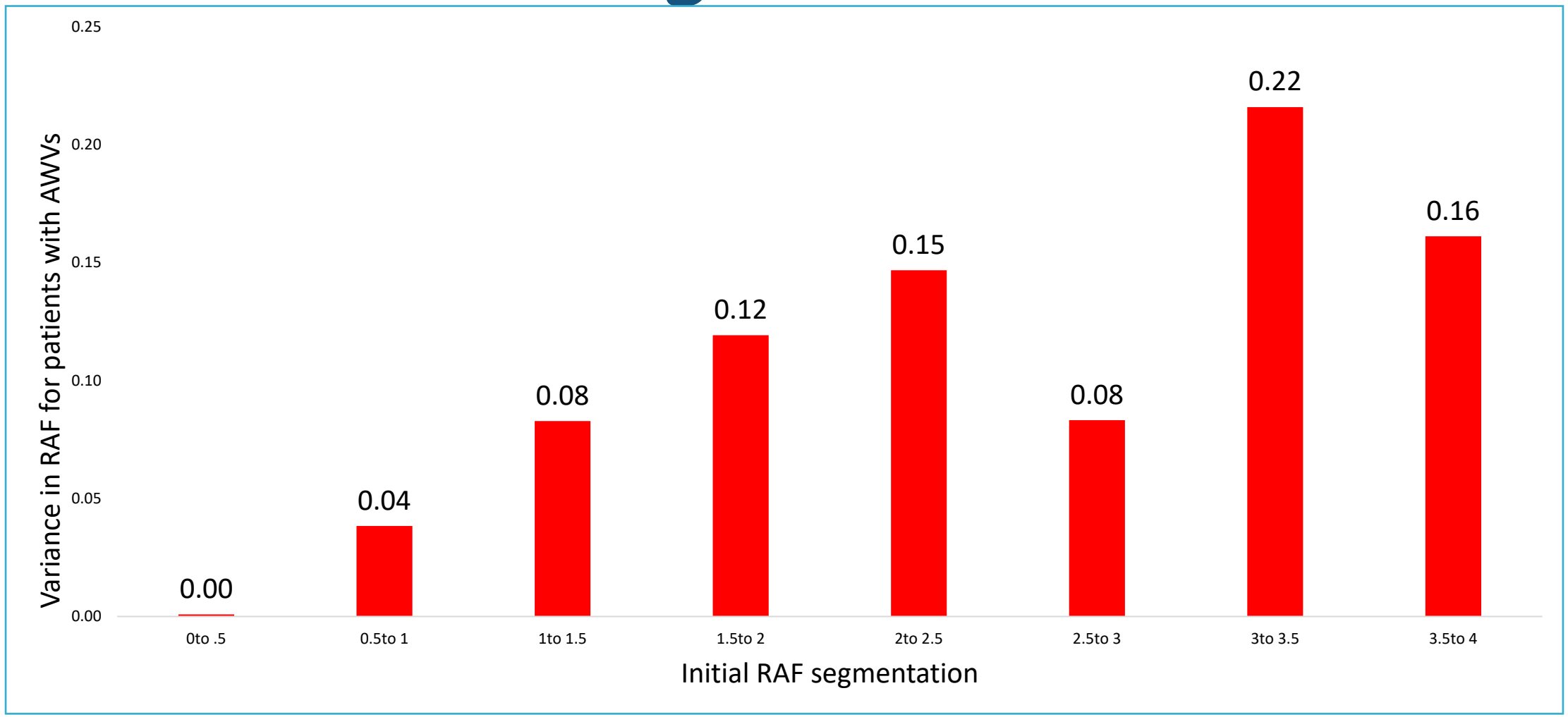


Summit Health + CITYMD

Population: Continuously attributed in NGACO in 2022-2021.

Patients with AWV

Higher RAF Gap Closure Across All Segments

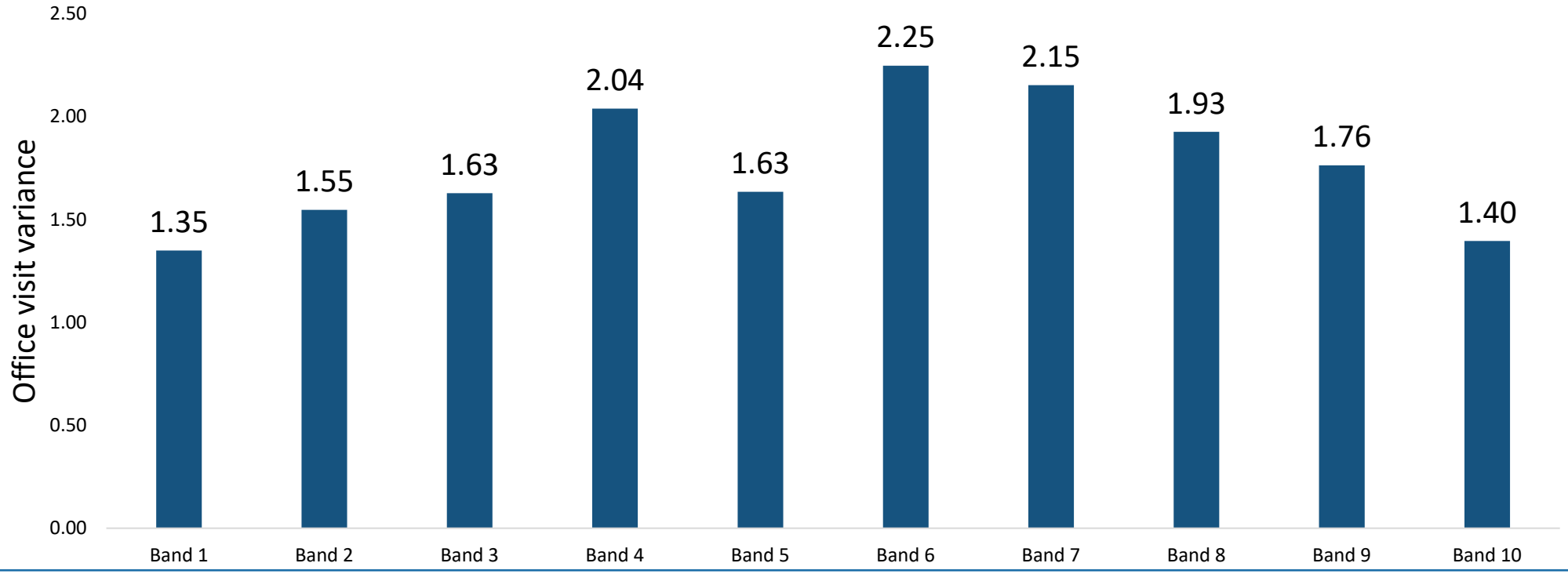


. Population: Continuously attributed in NGACO in 2022-2021.

Patients with AWV

Increase in # Outpatient Visits

AWVs generated more subsequent outpatient visits, on average 1.7 visits, which improved fee-for-service revenue.



Variance in office visits during 6 months post AWV compared to a comparable 6-month period in patients without AWVs. Bands represent risk deciles based on RAF.

Patients with AWV

Higher retention rate in NGACO attributed population

- Patients who had AWV in 2020 were 11% more likely to remain attributed in the 2021 NGACO population
- 77% of patients who did not have AWV were attributed where 88% who had AWV were attributed

2020 Attributed Members	2021 Attributed Members	AWV in 2020	Continued Attribution Rate
6,733	5,162	NO	76.67%
12,685	11,138	YES	87.80%

Variance in office visits during the 6 months post AWV compared to a comparable 6-month period in patients without AWVs. Bands represent the risk deciles based on RAF.

Sustainability and Scalability

How we are sustaining the impact

- **Value-Based Care Bootcamp**: Seven 1-hour seminars on closing quality gaps, improving clinical documentation, and engaging patients which includes the importance of AWVs.
- **AWVs + Comprehensive Care Visit**: AWV combined with a comprehensive care visit that addresses all acute and chronic conditions in addition to focusing on prevention and wellness.
- **Virtual AWV**: Offered virtually to those who cannot come to the office
- **Ongoing education of providers and staff:**
  - Q-Tips (Q-Tips & Q-Cards)
  - Pre-visit chart prep training
- **Solicit & Gather Feedback**: Continually improve processes and ensure reduced the stress on our care teams.
- **Hired Outreach Specialist:** ROI showed impact of AWV and recruited/hired Population Health outreach specialists to further engage and schedule patients eligible and/or overdue for a wellness visit

What Summit Health Learned

- AWV strategy is sustainable, scalable, transferrable and has a significant return on investment.
- AWVs positively impact value-based outcomes, AND also support fee for service revenue for outpatient care.
- Using an evidence-based approach and proving positive impact can justify progressive increases in investments to continually improve meaningful annual wellness visits.

KEY TAKEAWAYS

For a population wide strategy to be successful you must:

- Get buy-in from all that are involved
- Use a multi-faceted approach to attain your goal
- Measure the impact of your efforts along the way and adjust as needed
- Make investments to ensure long-term benefits

Identify & Engage Stakeholders + Process Improvements, Needed Investments + Actionable Transparent Reporting

Thank you

For your attention

Tabita Delisca, RN, MSN
Senior Quality Improvement Specialist
Tdelisca@summithealth.com

Improving Patient Outcomes, Quality Metrics and Total Cost of Care Savings through a Post-acute Care Nurse Navigator Role and Data Transparency between Skilled Nursing Facilities and St. Joseph's Health System

Jim Giordano
Executive Director St Joseph's Health Partners CIN
ACO Executive Mission Health Coordinated Care ACO
Email: Giordanoj@sjhmc.org

St. Joseph's Health Partners

MISSION HEALTH COORDINATED CARE ACO AT A GLANCE

- MSSP Enhanced Track E Program with two-sided risk
- Approximately 5,200 lives
- Care coordination by Clinically Integrated Network (CIN) staff:
    - Post-acute nurse navigator **
    - Two dedicated ACO nurse navigators
    - Social worker
    - Advanced Practice Nurse
    - Manager, Clinical Transformation
    - Quality Performance Managers
- High Performing Network of 10 Skilled Nursing Facilities (SNFs)
- Post-acute Data Analytics utilizing Real Time Medical Systems platform
- GPRO 2020:
    - Complete reporting on all measures
    - Final Quality Score- 97.5%

St. Joseph's Health Partners

GOALS and CHALLENGES

GOALS:

- Impact total cost of care savings in the post-acute setting, specifically through SNF patient management
- Decrease readmissions of SNF patients
- Decrease SNF LOS
- Improve relationships and collaboration with the SNF High Performing Network (HPN)

Challenges:

- Lack of SNF patients' clinical data available for review to impact treatment plan, readmissions and LOS
- Lack of dedicated navigator to review clinical data and manage care of the SNF patient population
- SNF buy-in to share patient data in order to have a *collaborative* approach to improve patient care and outcomes

SOLUTION: PAC NURSE NAVIGATOR ROLE

PAC Nurse Navigator (NN) position was created for the sole purpose of monitoring patients transitioning to a SNF as their next site of care

Responsibilities:

- Work collaboratively with the SNF care teams to determine anticipated discharge date within 48hours of transfer to SNF
- Participate in weekly Utilization Reviews (UR) to track patients' progress during their stay
- Monitor the medical condition of the patients while in the SNF using data analytics reports which risk stratify patients readmission risk
- Ensure SNF staff addresses changes in clinical status requiring intervention
- Assist with planning for transition home:
    - *arrange visiting nurse services together with the SNF social worker
    - *arrange follow-up visit with the PCP within 1 week of discharge
    - *supply the patient with the discharge summary from the SNF
    - *provide the patient and family with PAC NN phone number
- Follow patient for total of 1 month post hospital discharge to ensure a successful transition home

St. Joseph's Health Partners

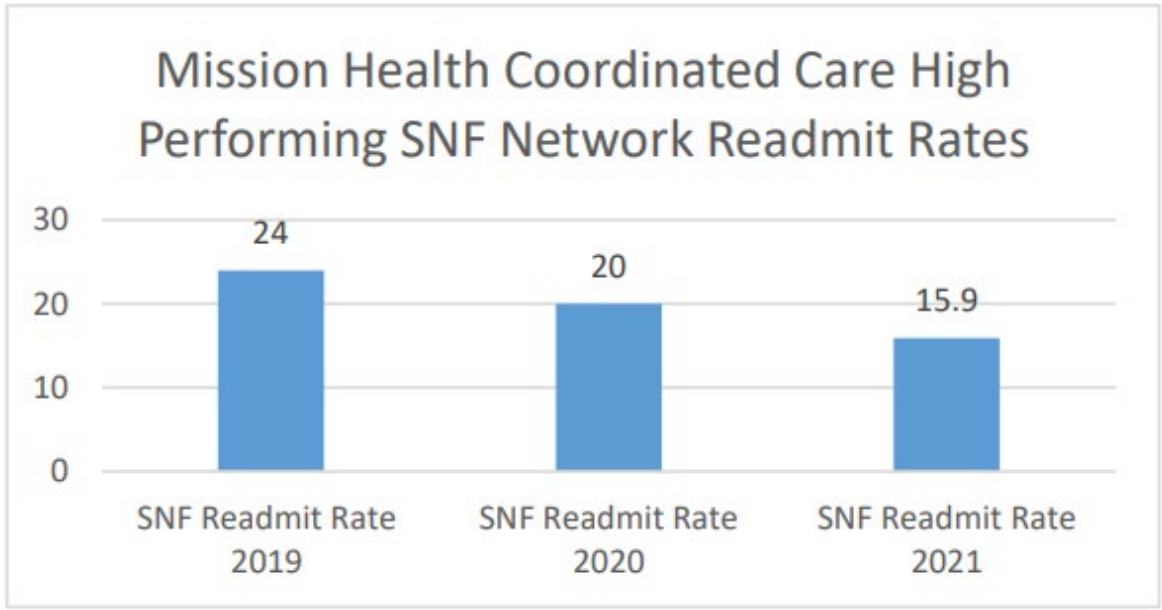
SOLUTION: PAC DATA ANALYTICS

Key to PAC NN success: Data transparency/SNF medical records access/ Impactable data analytics: Real Time Medical System

- Continuous evaluation of over 300 clinical indicators
- Daily risk stratification for patient readmission (Red/Yellow/Green) based upon clinical indicators--alerts PAC NN to patients that may need medical attention in order to prevent a potentially unnecessary or avoidable readmission
- Communications prompted by the data allow for intervention if patients do return to ED—ED Navigators notify MD-ACO pt/steer to OBS vs admit
- Analytics detailing timing or readmissions, medical reasons for readmissions, facility specific data…..ability for PAC NN to look for RA trends
- Ability to monitor LOS and skilled days in SNF for LTC patients
- Real Time support with monthly SNF readmission meetings and quarterly HPN SNF Town Hall meetings

IMPACT/OUTCOME

Significant reduction in readmission rate:



With each readmission costing the ACO an average of $14,700 these cost savings are estimated to be thirty-five (35) percent of the overall total cost of care savings generated by the ACO

St. Joseph's Health Partners

IMPACT/OUTCOME

- Collegial and collaborative relationship with the SNFs in our High Performing Network (HPN)
- Sharing of best practices between SNFs in the HPN during monthly readmission and quarterly town hall meetings
- Ability to monitor SNF LOS allowing for intervention for patients no longer requiring skilled care—resulting in cost of care savings
- Due to excellent outcomes, MHCC requires all SNFs requesting consideration to join our network, to demo and evaluate Real Time technology and strongly recommends implementation

Initiatives have not only impacted total cost of care savings, but they have also resulted in excellent quality performance

- In 2019, MHCC achieved a total cost of care savings of $1.779M and achieved a 100% quality score for complete reporting (1st year ACO)
- In 2020, MHCC achieved a total cost of care savings of $1,498,036 and a achieved a quality score of 97.5% with points earned for “Significant Improvement” in 2 of the 4 domains (CAHPS domain waived)

St. Joseph's Health Partners

COVID Vaccine Equity Reimagined for NC (COVER NC)

UNC Health Alliance

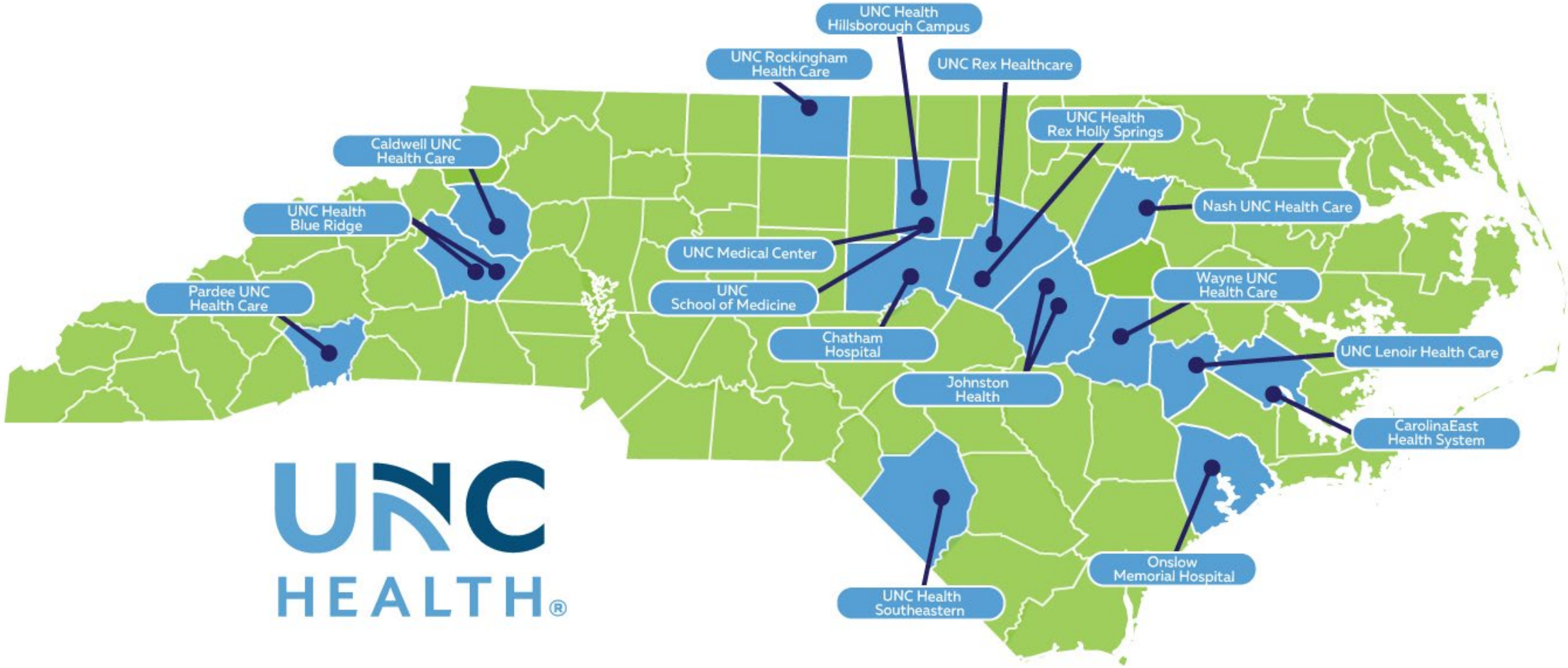
Matt Gitzinger, MHA, FACHE

System Director, Population Health Operations

Create equity in **OPPORTUNITY** for vaccination and
HOPE that translates into equitable **UPTAKE** of vaccination.

UNC HEALTH℠

UNC Health Serves North Carolinians Every Day.



UNC Health Alliance is UNC Health's Clinically Integrated Network, Accountable Care Organization and Population Health Services Organization

6,436 Providers with **2,316** Independent providers

1,131 Primary care providers

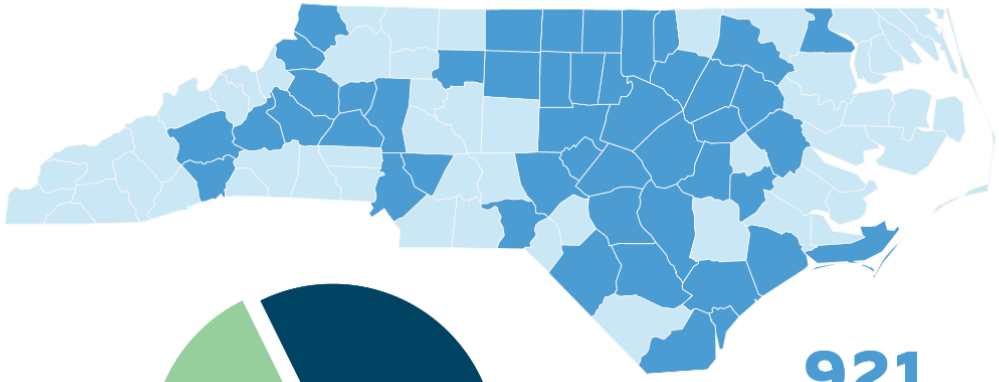
4,748 Specialty providers

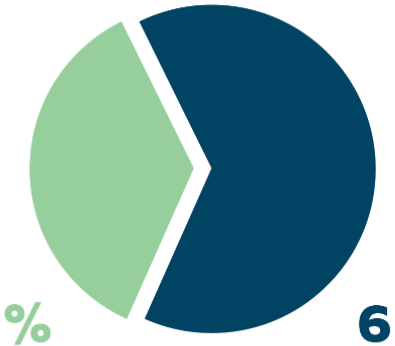
193 Specialties and subspecialties covered

SNF preferred network; home health preferred network

Community-based palliative care and hospice programs

UNCHA Network Across North Carolina





36% Independent Providers

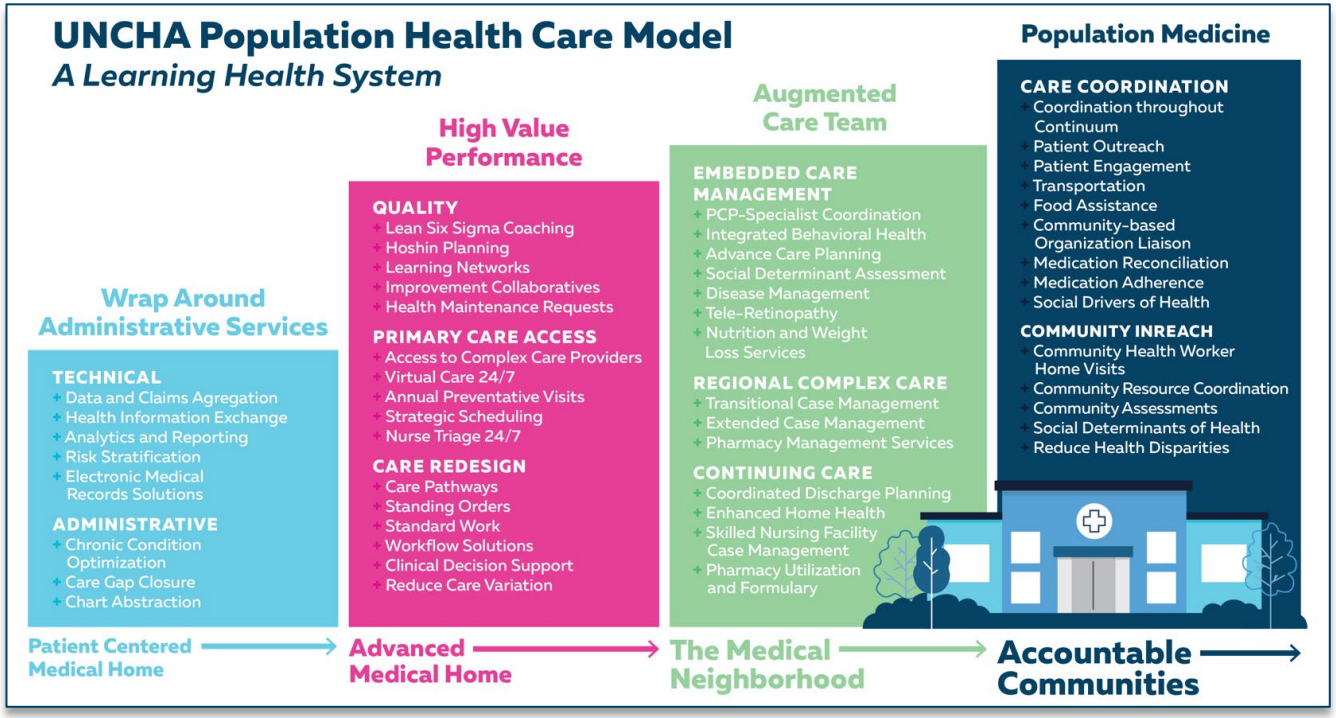
64% UNC Health Employed Providers

921 Locations in **48** Counties

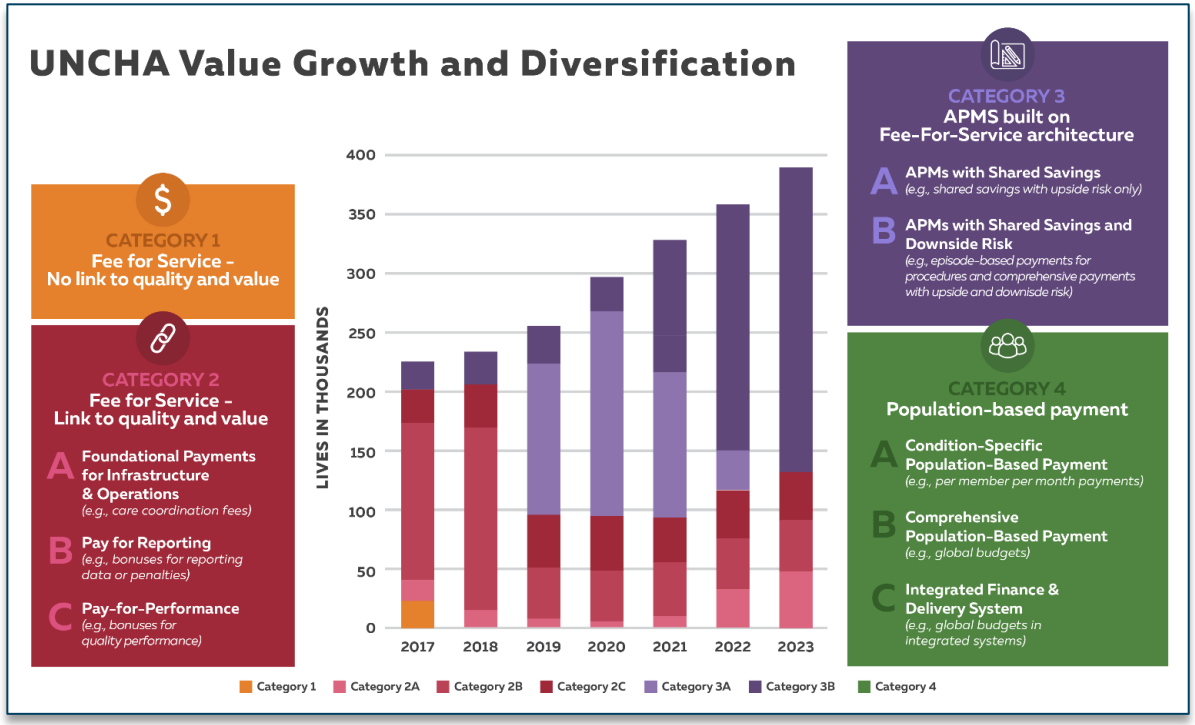
12 Hospitals

Success in Value – Built on a High Value Network, Strong Foundation of Population Health Services and Strategic Growth of Value Portfolio

We have a successful care model and operations…



… coupled with thoughtful and significant growth



COVID Vaccine Equity Reimagined for NC (COVER NC) was Developed to Address Health Equity for the Patients in NC

UNC Health, together with UNC Health Alliance committed to creating equity in OPPORTUNITY for vaccination among those in rural, minoritized, and marginalized communities..

A cross functional team of clinicians and support personnel came together to lead an equitable population health response to COVID vaccination (doses 1 and 2) with the following principles top of mind:

- Engage community leaders & organizations to **deliver solutions that marginalized communities want and need**
- Provide **multi modal access** to vaccination designed to address specific barriers faced by marginalized groups and being innovative in our approach, **while listening to our communities**
- **Preserve appointment capacity** for individuals within marginalized communities

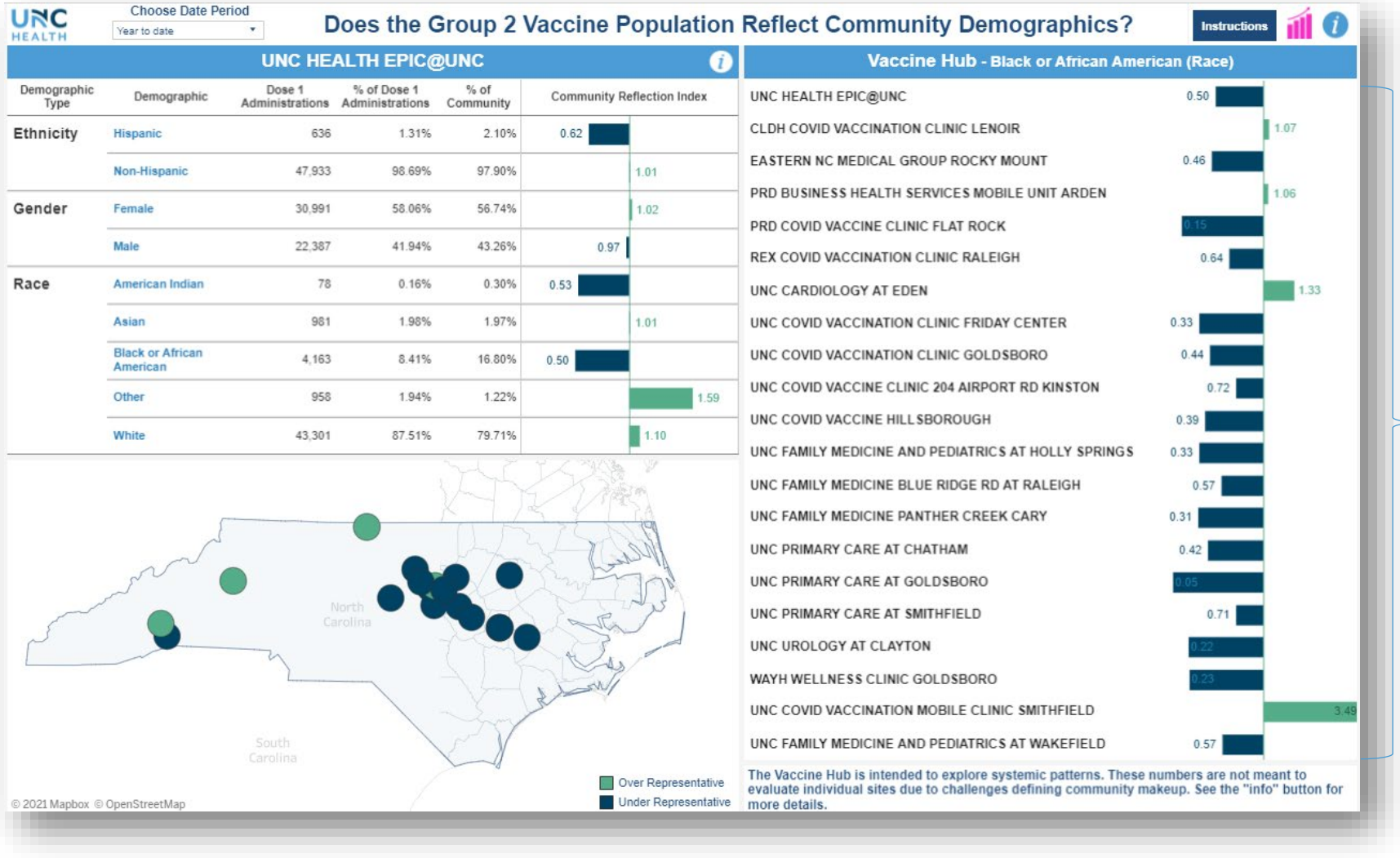
COVER NC: Project Framework

Analytics & Workflow Solutions	Community Pop Health Operations & Vaccine Partners	Access & Scheduling	Community Engagement
Reporting and analytics are needed to support operations, CQI/PDSA efforts and COVER NC strategy. **Data and other efforts will drive workflow changes and needs.**	COVER NC **success will require UNC, non-UNC, and community partner clinical effort**.	**Equity begins with intentional effort** to manage and identify access needs and develop culturally acceptable solutions, reducing barriers and meeting the community where they are.	**Communications and outreach will be critical.** We will need to use numerous means to engage communities.
• Develop **solutions for community partners** to provide a list of patients who are eligible for vaccination. • Develop solutions for community partners' events and patient "walk by" opportunities. • Develop **solution to manage inbound calls** to team where demand exceeds vaccine availability.	• Work with community vaccination partners to **understand their needs** and our capacity to support. • Identify partners to pilot **community-based registration**, once available.	• Manage high inbound call volumes • **Finalized REaL one-page data collection quick reference guide**. • Working a **consolidated scheduling team** for a coordinated approach.	• Compile list of current partners that can be leveraged as **community advocates** and/or vaccination sites. • Develop flyers that encourage **patients to share their story.** • Develop social media toolkit for community partner use.

Improving vaccine equity would require a focused team from across the organization, with diverse skills and relationships.

Step 1: Evaluated Initial Equity at Vaccine Hubs

Community Reflections Index (data thru 2/10/21)



Vaccine Hubs
Each location or bar to the left represents a different "Vaccine Hub".

Vaccine Hubs were located across the state, with many co-located in larger primary care practices and UNC Health office buildings.

The goal was to make vaccine appointments easily accessible, including parking.

< 1 = under-represented population **>1 = over-represented population**

Step 2: Developed Vaccine Access and Outreach Strategy

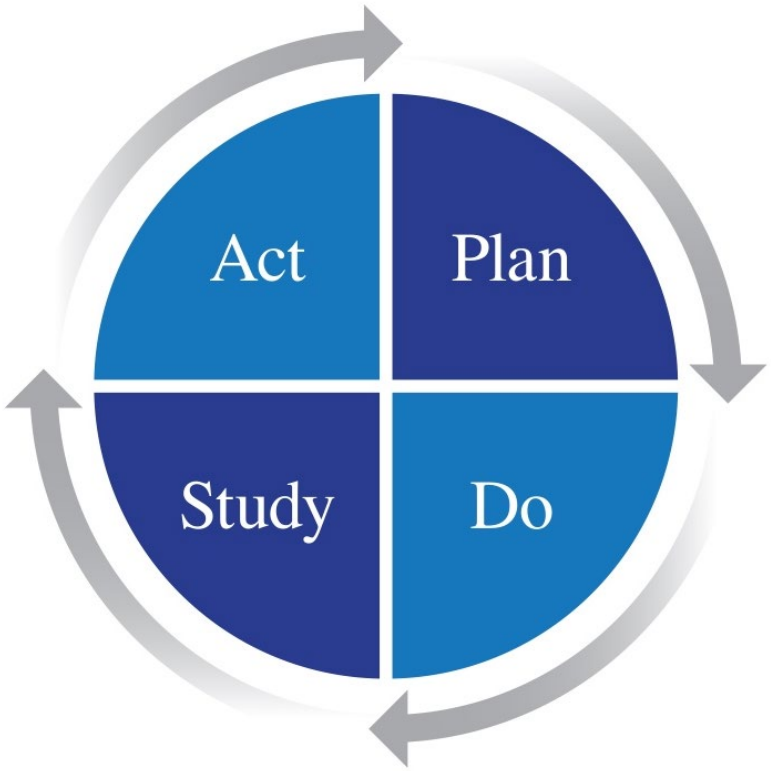
We deployed numerous tactics to meet the needs of the underserved and pivoted up to 85% of UNC Health Alliance staff to mount this population-based response.

Epic-Based Outreach		Community-Based Outreach		Community-Based Vaccinations	
Telephonic Scheduling	**Scheduling via Text**	**Community Registration**	**Community Scheduling**	**Mobile Vaccinations**	**Community Vaccination Partners**
Robocalls and scheduler outbound calls to patients that do not have an email or mobile phone.	**Text message** with scheduling link, to patients that have a mobile phone.	**Web-based registration** process to allow community partners to serve as registration site. Registered individuals receive email/text/phone call to schedule appointment.	**Web-based scheduling** process that allowed community partners to "schedule" individuals for vaccination using direct scheduling links.	**Vaccinations** provided within historically underserved communities via the UNC Health mobile unit.	**Vaccine supply transferred** to clinical partners providing services within historically underserved areas (i.e. FQHCs, pharmacies in underserved areas).

Step 3: Analyzed Outreach Tactics through Weekly PDSA Cycles

Improve opportunity for the historically marginalized to get vaccinated

Foundational to our learning organization



PDSA #1

- Focus on locations with vaccine allocation
- Set up one, new COVER NC phone line

Logic
- Limit to zip codes near vaccine sites
- Patients with no MyChart
- Age ≥75 years
- Oversampled marginalized communities

Considerations
- Prioritize scheduling households
- Ask & offer transportation services

Results
- Reduced gap in CRI by 6% (5.3% to 6.11%)

PDSA #2

ew locations with allocation
reams: 34% Community Line
ts reserved for COVER NC

erty level at zip level
ine sites
o ≥65 years
marginalized communities
nts with all communication
e, cell, MyChart, e-mail)

- Limit batches to not exceed appointment supply
- Pace Text & Robocall
- Response time to bulk outreach can take 1+ days

Results
- Reduced gap in CRI by 25% (6.1% to 8.2%)

PDSA #3

allocation
tlist and existing COVER NC

in age and demographics and
us

e Poverty Level census tracts
lemographics proximal to sites
k existing and expanded

ns
C line inundated by non-
d audience

One Year of COVID-19 Vaccines from UNC Health's Mobile Unit

Mobile Unit
one example
of several tactics
to deliver
vaccines equitably

Total Events: 43

Counties Visited: 6

COVID-19 & FLU

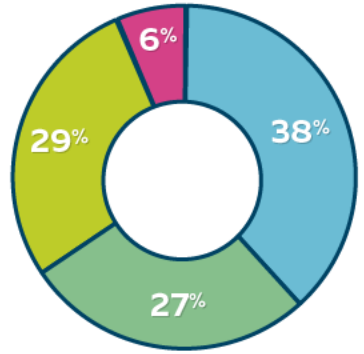
Vaccines Administered:
4,140

Patients Vaccinated:
2,489

PATIENTS SERVED

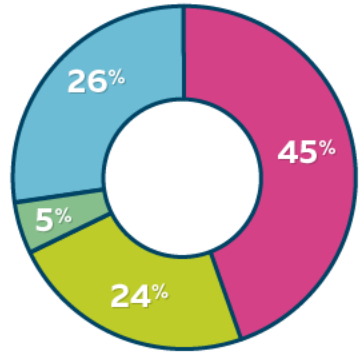
Racial Demographics

- Black/African American: 1581
- Hispanic or Latino: 1141
- White: 1159
- Other, non-Hispanic: 259



Financial Class

- Self-Pay/Medicaid pending: 1,111
- Medicare: 580
- Medicaid: 140
- Commercial (including SHP): 658



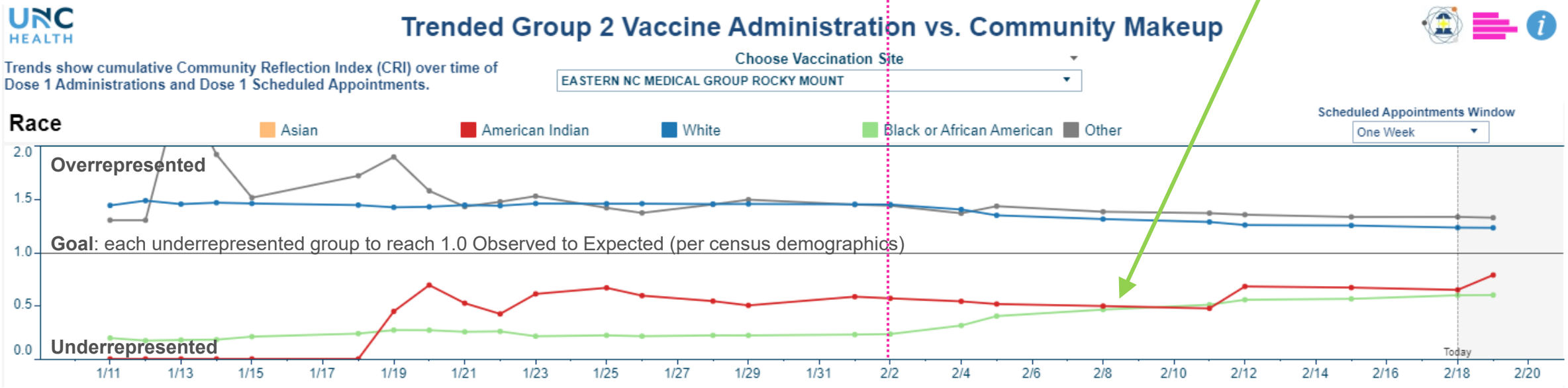
UNC HEALTH

Step 4: Monitored vaccine administration as a reflection of our community

1/25-2/16 Outreach Campaign by method for one rural hub

COVER NC Outreach Campaign begins to Eastern North Carolinians for one rural vaccine hub

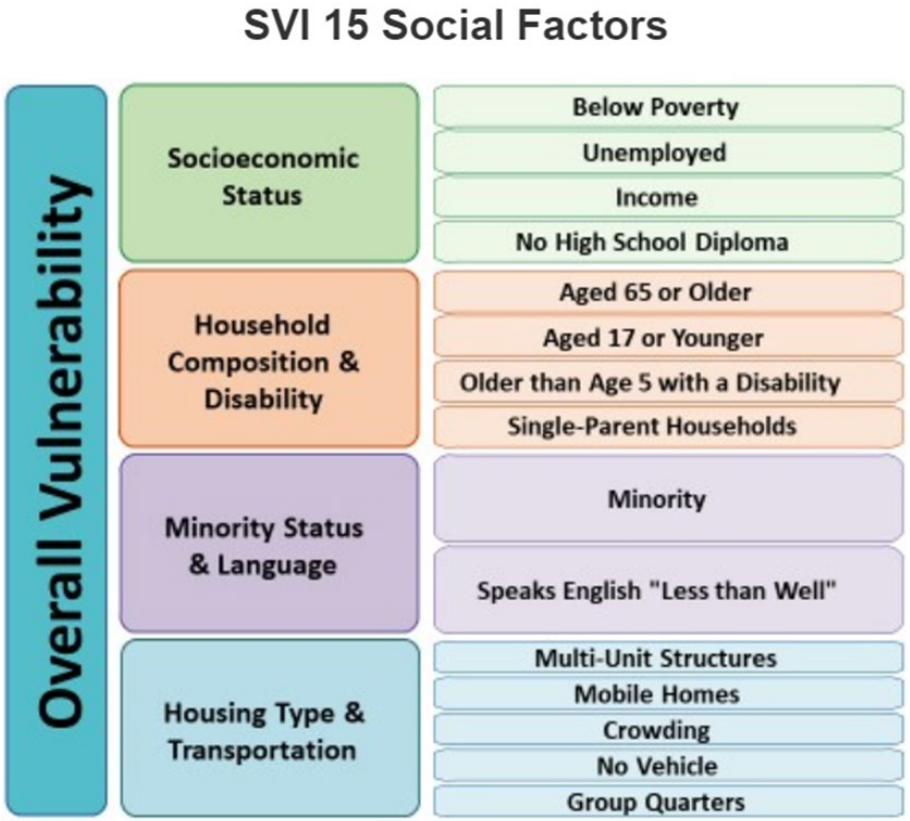
Note the 0.37 improvement in vaccination rate among Black residents from baseline:
0.23 CRI on 2/2/21 - 0.6 CRI on 2/18/21



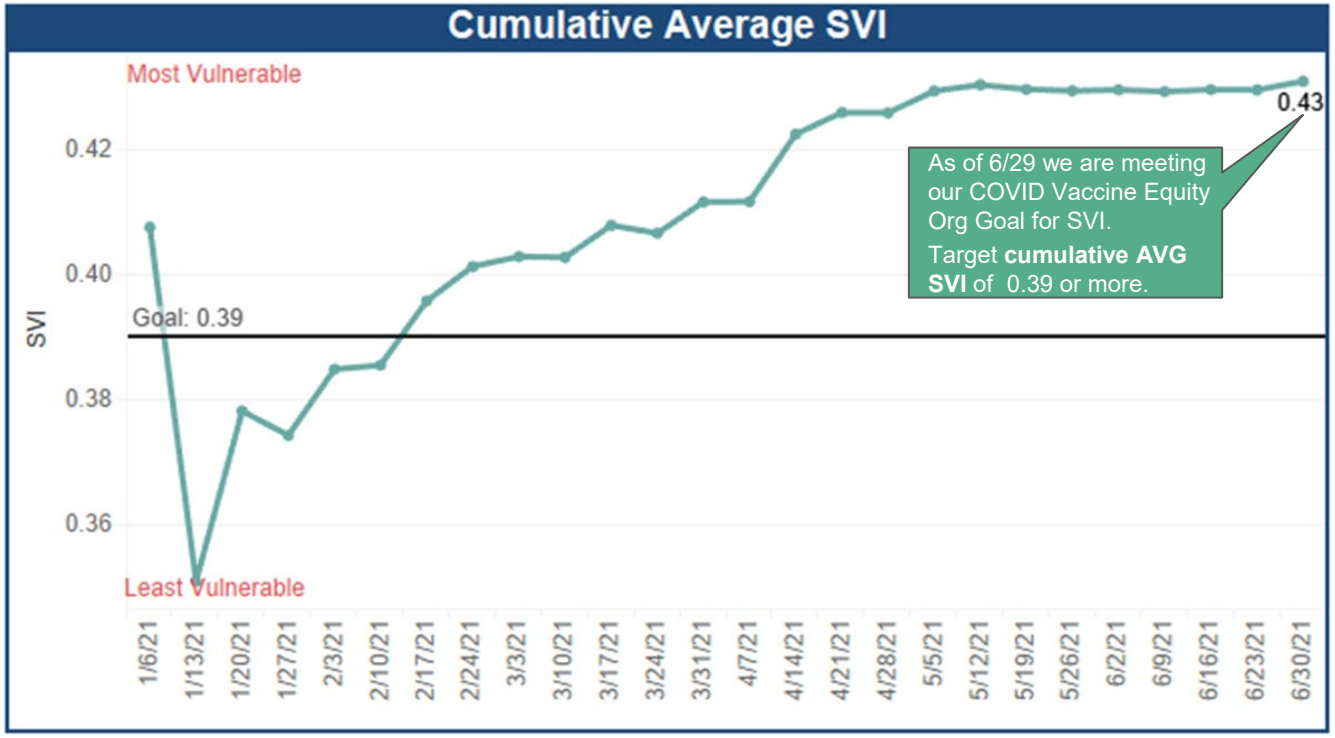
The same methodology was applied to other demographics and REaL elements (ethnicity and gender) as needed across vaccine hubs.

Step 5: Deployed more comprehensive measures of vulnerability

Using the CDC Social Vulnerability Index (SVI) to focus on each patient



- Each County and census tract is ranked from 0 to 1 (1 = most vulnerable) – each patient assigned a SVI
- We are asking ourselves, are we reaching vulnerable patients within the communities that we serve?



- This includes both internal & external vaccinations
- Successful in achieving our goals through entities' relationships and other efforts to work in partnership with communities

Results: Improved vaccine administration as a reflection of our community

The Community Reflection Index (CRI) Pre and Post COVER NC

Pre-COVER NC (All ages) 1/1/21-1/31/21

PRE — UNC HEALTH EPIC@UNC (All)

Demographic Type	Demographic	Dose 1 Administrations	% of Dose 1 Administrations	% of Community	Community Reflection Index
Race	American Indian	42	0.13%	0.41%	0.32
	Asian	653	2.04%	3.90%	0.52
	Black or African American	1,741	5.44%	20.46%	0.27
	Other	606	1.89%	4.54%	0.42
	White	28,947	90.49%	70.69%	1.28
Gender	Female	19,167	56.55%	52.35%	1.08
	Male	14,724	43.45%	47.65%	0.91
Ethnicity	Hispanic	387	1.23%	7.93%	0.16
	Non-Hispanic	31,052	98.77%	92.07%	1.07

COVER NC (All ages) 2/1/21 – 7/13/21

UNC HEALTH EPIC@UNC (All)

Demographic Type	Demographic	Dose 1 Administrations	% of Dose 1 Administrations	% of Community	Community Reflection Index
Race	American Indian	303	0.26%	0.41%	0.62
	Asian	8,682	7.41%	3.90%	1.90
	Black or African American	18,948	16.17%	20.46%	0.79
	Other	8,718	7.44%	4.54%	1.64
	White	80,495	68.71%	70.69%	0.97
Gender	Female	63,493	53.77%	52.35%	1.03
	Male	54,594	46.23%	47.65%	0.97
Ethnicity	Hispanic	8,363	7.15%	7.93%	0.90
	Non-Hispanic	108,601	92.85%	92.07%	1.01

The closer the CRI is to 1.0, the truer our vaccine delivery reflects our community

COVER-NC (65 yo+) 2/1/21 – 7/13/21

UNC HEALTH EPIC@UNC (≥ 65 y/o)

Demographic Type	Demographic	Dose 1 Administrations	% of Dose 1 Administrations	% of Community	Community Reflection Index
Race	American Indian	47	0.19%	0.31%	0.63
	Asian	618	2.54%	1.96%	1.30
	Black or African American	4,853	19.98%	16.71%	1.20
	Other	691	2.84%	1.22%	2.33
	White	18,080	74.44%	79.81%	0.93
Gender	Female	14,173	57.76%	56.68%	1.02
	Male	10,364	42.24%	43.32%	0.98
Ethnicity	Hispanic	588	2.43%	2.09%	1.16
	Non-Hispanic	23,597	97.57%	97.91%	1.00

Overrepresented (Community Reflection Index > 1)

- Black race (120% of expected)
- Asian race (130% of expected)
- Hispanic ethnicity (116% of expected)

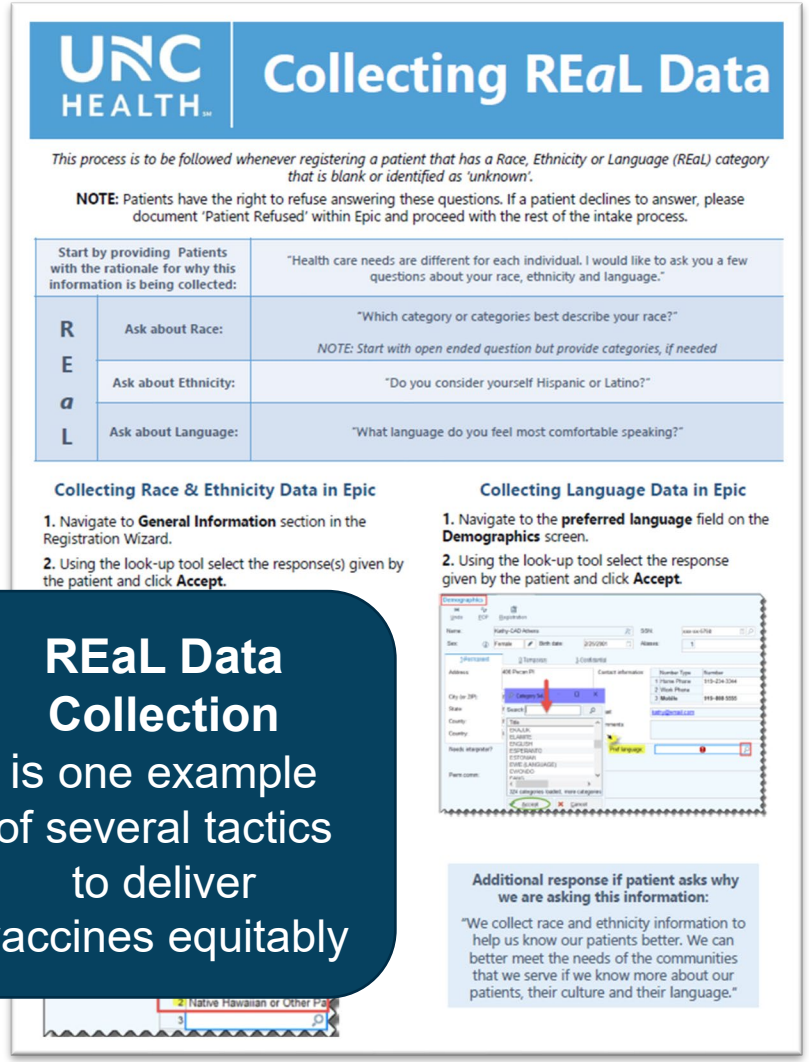
Underrepresented (Community Reflection Index < 1)

- White race (93% of expected)
- American Indian race (63% of expected)

>1 = over-represented population < 1 = under-represented population

Learnings and Next Steps

Using data to focus on other health inequities



UNC HEALTH

Collecting REaL Data

This process is to be followed whenever registering a patient that has a Race, Ethnicity or Language (REaL) category that is blank or identified as 'unknown'.

NOTE: Patients have the right to refuse answering these questions. If a patient declines to answer, please document 'Patient Refused' within Epic and proceed with the rest of the intake process.

Start by providing Patients with the rationale for why this information is being collected:		"Health care needs are different for each individual. I would like to ask you a few questions about your race, ethnicity and language."
R	Ask about Race:	"Which category or categories best describe your race?" *NOTE: Start with open ended question but provide categories, if needed*
E	Ask about Ethnicity:	"Do you consider yourself Hispanic or Latino?"
a		
L	Ask about Language:	"What language do you feel most comfortable speaking?"

Collecting Race & Ethnicity Data in Epic

1. Navigate to **General Information** section in the Registration Wizard.
2. Using the look-up tool select the response(s) given by the patient and click **Accept**.

Collecting Language Data in Epic

1. Navigate to the **preferred language** field on the **Demographics** screen.
2. Using the look-up tool select the response given by the patient and click **Accept**.

Additional response if patient asks why we are asking this information:

"We collect race and ethnicity information to help us know our patients better. We can better meet the needs of the communities that we serve if we know more about our patients, their culture and their language."

REaL Data Collection is one example of several tactics to deliver vaccines equitably

- **Lessons Learned:**
  - New equity lens applied to the work we do
  - REaL data requires ongoing focus
  - Transportation and access close to home are critical
- **UNC Health Alliance continues to:**
  - Leverage the use of Race Ethnicity and Language (REaL), Community Reflection Index (CRI), and Social Vulnerability Index (SVI) to identify and close disparities in quality, access, safety and patient experience
  - Facilitate the development of a comprehensive system-wide strategy for the care of Spanish speaking patients
  - Apply new data assets within population health interventions and quality improvement effort
  - In partnership with the Office of Health Equity and entities, build upon the experience of COVID to develop lasting community health interventions