Introduction to Cone Health/Stroke Program/Center for Health Equity

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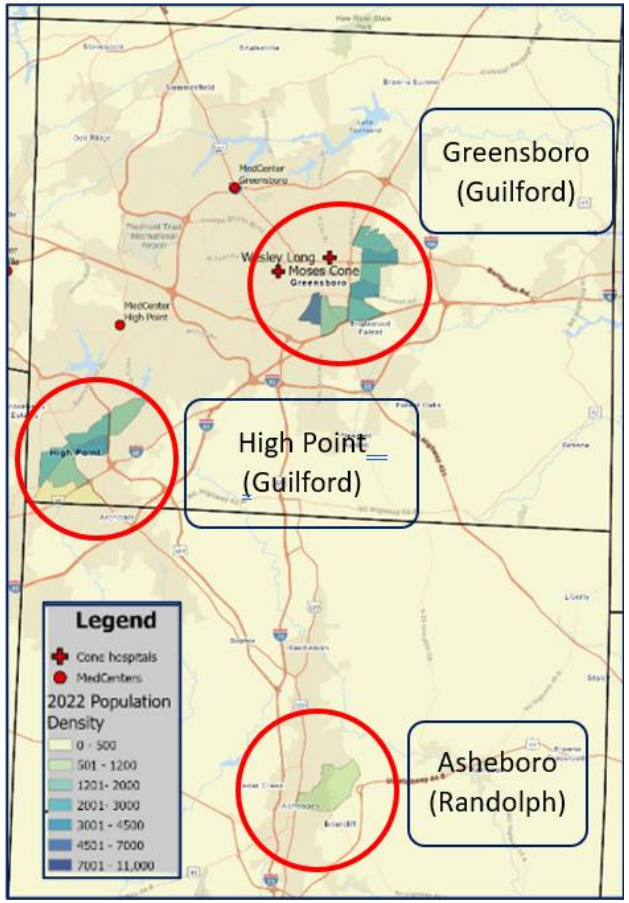
Our prior involvement with Coverdell

- **2002**: Tri-State Stroke Network Prevention and Control Subcommittee (Sharon Biby, RN)
- **2008**: Grant from the NC Stroke Care Collaborative to electronically capture code stroke data for QI improvement opportunities
- **2022**: - MC was subawardee of a subaward grant given to Mission Hospital by the NC DHSS Paul Coverdell grant to look at manual vs automatic BP results in acute hemorrhage patients
- **2004 to present**: Coverdell Data Set submitted to NC Stroke Registry (various iterations over the years)

Our proposed geography



Year	County	City	Census tract	Census Prevalence Rate*	County Prevalence Rate*	Census compared to County
2021	Guilford	Greensboro	37081011300	7.6	3.4	2.24
2021	Guilford	Greensboro	37081011102	7.4	3.4	2.18
2021	Guilford	High Point	37081013800	6.7	3.4	1.97
2021	Guilford	Greensboro	37081012705	6	3.4	1.76
2021	Guilford	Greensboro	37081012706	6	3.4	1.76
2021	Guilford	High Point	37081013900	6	3.4	1.76
2021	Guilford	Greensboro	37081011400	5.9	3.4	1.74
2021	Guilford	High Point	37081014501	5.4	3.4	1.59
2021	Randolph	Asheboro	37151030302	6	3.8	1.58
2021	Guilford	High Point	37081014000	5.3	3.4	1.56
2021	Guilford	High Point	37081014406	5.2	3.4	1.53
2021	Guilford	High Point	37081014300	5.1	3.4	1.5
2021	Guilford	Greensboro	37081012707	5.1	3.4	1.5
2021	Guilford	Greensboro	37081011101	5.1	3.4	1.5

*Crude stroke prevalence rate from BRFSS data, NCDHHS.

Our team

Personnel		
Position	Name	% of FTE
Program Manager	Vacant, advertised	80%
Community Health Workers	Vacant, to be hired (2)	100%
Project Manager	Margaret Currie-Coyoy	50%
Financial Analysis Manager	Adam DeCoteau	10%
Data Analytics	Xavier Leak	20%
Population Health Manager	Eleanor Rivers	10%
Care Management Coordination	Amanda Rose	40%
Stroke Center Program Manager	Sharon Biby	10%
Stroke Quality Coordinator	Amber Carter	10%
		Total:

Highlights of our Y1 workplan

- Create a dedicated project team of stroke subject matter experts (SMEs) and data analysts to identify patients who have experienced a stroke and those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension in our targeted census tracts
- Create and fill two Community Health Workers (CHWs) positions to support this project
- Create a diverse HBHR Stroke Program advisory council to oversee, engage with, and advise the program team on grant-related activities
- Develop and implement a robust and ongoing quality improvement plan
- Create a referral pathway for our inpatient stroke rehab teams to refer patients meeting the high burden, high risk (HBHR) criteria for into our program for support and follow-up
- Identify new partners in our targeted census tracts to help us expand the reach of our community education and prevention efforts
- Work with our EMS partners in Guilford and Randolph Counties to understand opportunities to increase the percentage of people who use EMS when experiencing stroke
- Develop, refine and maintain a library of culturally competent stroke prevention and education resources for dissemination to our patients, internal teams, and community partners

Highlights of our Y2-5 workplan

- Increase our use of electronic medical record (EMR) to identify those who have experienced a stroke and those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension
- Use our SDOH screening built into our EMR to ensure all patients we contact as part of this project are screened for SDOH needs
- Identify and establish relationships with stroke support groups in our three areas of focus (Greensboro, High Point and Asheboro NC), ensuring that they understand the project activities and can refer patients who meet the criteria into our HBHR project for support
- Provide regular in-service education sessions to our internal (primary care, inpatient stroke care, health equity outreach, mobile medicine, and Congregational and community nursing) teams as well as our community partners
- Implement a communication system to unite the stroke continuum care team in a single, unified communication channel
- Create and provide durable stroke prevention signage and educational materials for businesses and agencies within our target census tracts to expand community awareness

Opportunities for collaboration: Strategy 1

Strategy 1: Track, monitor, and assess clinical and social services and support needs measures and referrals across the stroke continuum of care for those who have experienced a stroke, those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension, and to identify health care disparities.	
1A. Leverage electronic health records (EHRs) and health information technology (HIT) to identify those who have experienced a stroke and those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension.	**Increased use of EHR and HIT to identify those who have experienced a stroke and those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension.**
1B. Use standardized procedures to identify clinical and social services and support needs for those who have experienced a stroke and those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension to monitor and assess referrals and use of those services through a bidirectional referral system.	**Increased use of standardized procedures to identify, monitor, and assess clinical and social services and support needs, and to provide referrals to those services and assess their utilization through a bidirectional referral system.**

Opportunities for collaboration: Strategy 1

Strategy 1: Track, monitor, and assess clinical and social services and support needs measures and referrals across the stroke continuum of care for those who have experienced a stroke, those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension, and to identify health care disparities.	
1C. Use metrics from EHR, HIT, and program data to guide quality improvement activities, e.g., Plan Do Study Act (PDSA) cycles, participant and partner feedback, etc.	**Increased use of metrics from EHR/ HIT and program data to guide quality improvement activities.**
1D. Describe, monitor, and assess statewide data across the stroke continuum of care within proposed service areas for those who have experienced a stroke and those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension.	**Increased monitoring and assessment of statewide data across the stroke continuum of care and within proposed service areas for those who have experienced a stroke and those at the highest risk of stroke due to undiagnosed or uncontrolled hypertension.**

Opportunities for collaboration: Strategy 3

Strategy 3: Link individuals to community resources and clinical services to support bidirectional referrals, self-management, and lifestyle changes for those who have experienced a stroke and those at the highest risk of stroke and to mitigate barriers to social services and support needs to improve outcomes.	
3A. Establish and strengthen partnerships with relevant state or local stroke coalitions, learning collaboratives, initiatives, community-based organizations, non-governmental organizations, professional organizations, providers, and health systems that provide support for those who have experienced a stroke and those at the highest risk of stroke across the continuum of care.	**Increased number of newly established and strengthened partnerships that provide support for those who have experienced a stroke and those at the highest risk of stroke across the stroke continuum of care.**

Opportunities for collaboration: Strategy 3

Strategy 3: Link individuals to community resources and clinical services to support bidirectional referrals, self-management, and lifestyle changes for those who have experienced a stroke and those at the highest risk of stroke and to mitigate barriers to social services and support needs to improve outcomes.	
3B. Facilitate the engagement of the community-based workforce (including community health workers, community health representatives, social workers, patient navigators, etc.) in managing community resources and clinical services that support those who have experienced a stroke and those at the highest risk of stroke across the continuum of care to improve outcomes.	**Increased engagement of the community-based workforce (including community health workers, community health representatives, social workers, patient navigators, etc.) across the stroke continuum of care to manage community resources and clinical services for those who have experienced a stroke and those at the highest**
3C. Promote and coordinate appropriate messaging and education to increase the prevention and awareness of stroke across the continuum of care.	**Increased reach of stroke prevention messaging and education across the stroke**

Q&A