# NC COVERDELL PROGRAM RESOURCES

# **STROKE SYSTEMS OF CARE**

### **CDC Stroke Systems of Care: Policy Evidence Assessment Reports**

Policy evidence assessment reports prioritize stroke policy interventions by these evidence levels: best, promising, or emerging.

https://www.cdc.gov/coverdell/php/report/stroke-pear.html

American Stroke Association Stroke Journal Recommendations for the Establishment of Stroke Systems of Care: A 2019 Update

#### **NC Stroke System of Care**

The Stroke Advisory Council developed NC Stroke System of Care Strategies to support efforts to prevent strokes; increase access to care; increase quality, coordinated care; enhance recovery from stroke; and advocate for the prevention and management of stroke.

# HEALTH EQUITY/SOCIAL DRIVERS OF HEALTH RESOURCES

# CDC's Office of Health Equity

CDC's Office of Health Equity's (OHE) mission is to ensure health equity is embedded in an all-of-public health approach to overcoming persistent health disparities and health inequities across a range of population groups that disproportionately experience poor health outcomes. <a href="https://www.cdc.gov/health-equity/about/index.html">https://www.cdc.gov/health-equity/about/index.html</a>

### NC Office of Health Equity

The Office of Health Equity has created a resource list in the link below for anyone looking for more information on health equity. The resources are on various topics including communication equity in presentations and communicable disease response, as well as policies and articles written by NCDHHS staff. This page will be updated regularly as new information and resources are gathered.

https://www.ncdhhs.gov/divisions/office-health-equity/health-equity-resources

# Standardized Screening for Health-Related Resource Needs in North Carolina

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

#### **CDC Community-Clinical Linkages**

https://www.cdc.gov/heart-disease/docs/CCL\_Health\_Equity\_Guide-508.pdf

# NC Health Disparities Analysis Report



HealthDisparitiesAnal ysisReport\_9.10.24\_En

## **QUALITY IMPROVEMENT RESOURCES**

# **CDC Performance Management & Quality Improvement:**

The concepts, resources, and links are intended to support state, tribal, local and territorial health departments as they head down the path of improving their performance.

https://www.cdc.gov/public-health-gateway/php/communications-resources/performance-management-quality-improvement-resources.html

## **American Society for Quality**

Plan-Do-Check-Act (PDCA) Cycle

Variations: plan-do-study-act (PDSA) cycle, Deming cycle, Shewhart cycle. Understand the evolution of these variations.

The Plan-do-check-act cycle is a four-step model for carrying out change. Just as a circle has no end, the PDCA cycle should be repeated again and again for continuous improvement. The PDCA cycle is considered a project planning tool.

https://asq.org/quality-resources/pdca-cycle

## **BI-DIRECTIONAL REFERRALS**

## **CDC: Implementing Bi-Directional Referrals**

The <u>Implementing Bi-directional Referrals webinar</u> presents a case study completed in 2020 as part of CDC's key effort to scale the National Diabetes Prevention Program in areas that are underserved.

https://nationaldppcsc.cdc.gov/s/article/Implementing-Bi-directional-Referrals-Webinar-and-Strategy-Guide

## **NCDHHS**

Many North Carolinians struggle every day with food insecurity, housing instability, lack of transportation access, or other non-medical social needs. NCCARE360 is the first statewide coordinated care network that better connects individuals to local services and resources.

https://nccare360.org/

#### INTERDICIPLINARY CARE TEAMS/COMMUNITY HEALTH WORKERS

#### **American Hospital Association**

Effective and sustainable hospital-community partnerships are critical to building a Culture of Health. Building a Culture of Health means creating a society that gives all individuals an equal opportunity to live the healthiest life they can, whatever their ethnic, geographic, racial, socioeconomic or physical circumstances may be.

https://www.aha.org/system/files/hpoe/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf

#### NC Office on Rural Health Community Health Workers

The North Carolina Community Health Workers (CHW) section provides a dedicated area for community health workers and allies to access information at the local, state, and national levels. It also serves as the home for the North Carolina CHW Alliance and a compendium of resources, events, and news about opportunities for certification, core competency training, and specialty training offerings.

https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers

### **CDC Community Health Worker Toolkit**

Resources include online courses, lessons learned, and best practices to help train and build capacity for CHWs in their communities.

https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm

Interdisciplinary Care Teams, Patient Navigators, and Community Health Workers

These models focus on the use of interdisciplinary care teams, patient navigators, and community health workers (CHWs) to help address social determinants of health in healthcare settings. Find information and tool kits from the Rural Health Information Hub:

https://www.ruralhealthinfo.org/toolkits/sdoh/2/healthcare-settings/care-teams

### **CPSTF Recommends Community Health Worker Interventions to Prevent Cardiovascular Disease**

The <u>Community Preventive Services Task Force (CPSTF) recommends</u> interventions that engage community health workers to prevent cardiovascular disease (CVD) among clients at increased risk.

https://www.thecommunityguide.org/findings/cardiovascular-disease-prevention-and-control-interventions-engaging-community-health

## **Community Paramedic Programs**

The information provided demonstrates the value of community paramedicine programs to partners that are addressing their communities' post stroke needs as well as those at risk for stroke due to uncontrolled or undiagnosed hypertension. Community paramedicine fills gaps in primary and preventive care services by coordinating care and addressing SDOH. <a href="https://www.cdc.gov/ems-community-paramedicine/php/data-research/community-paramedicine/index.html">https://www.cdc.gov/ems-community-paramedicine/php/data-research/community-paramedicine/index.html</a>