Start With Your Heart®

Justus-Warren Heart Disease & Stroke Prevention Task Force

Stroke Advisory Council

November 12, 2025

Housekeeping

- Mute your microphones.
- Type your comments and questions in the Chat.
- Raise your hand if you'd like to speak.

Agenda

I. Welcome and Approval of Minutes

II. Leadership and Member Changes

- Chuck Tegeler, MD
- Amy Guzik, MD-SAC Vice Chair
- Anna Bess Brown-Executive Director
- Michael Erwin-Stroke Survivor
- Anthony Davis-NCOEMS

Agenda

III. Task Force Update

IV. Legislative Update

V. Coverdell Stroke Program Update

VI. Lessons from Target Stroke III: Improving Thrombolytic *and* Endovascular Care

Coverdell Acute Stroke Program

- Improve equity and quality in stroke prevention and care
  - Enhanced data collection
  - Strengthen linkages between clinical and community resources
  - Prevent strokes through hypertension detection and control
  - Provide bi-direction referrals for patients' social and clinical health needs

PAUL Coverdell
NATIONAL ACUTE STROKE PROGRAM

ATRIUM HEALTH – WAKE FOREST BAPTIST HOSPITAL

- Enhancing Data Collection:
  - Collaborate health informatics team to develop real-time monitoring dashboards within the EHR
  - Implement automated system within the EHR, flags hospitalized stroke or TIA patients with uncontrolled hypertension for post-stroke care coordination
- Quality Improvement Project:
  - Addressing SDOH needs in recently hospitalized stroke patients
  - In partnership with the Piedmont Triad Regional Council Area Agency on Aging

Transforming Stroke Care: Addressing Social Determinants of Health Needs in Hospitalized Stroke Patients

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Background and Importance

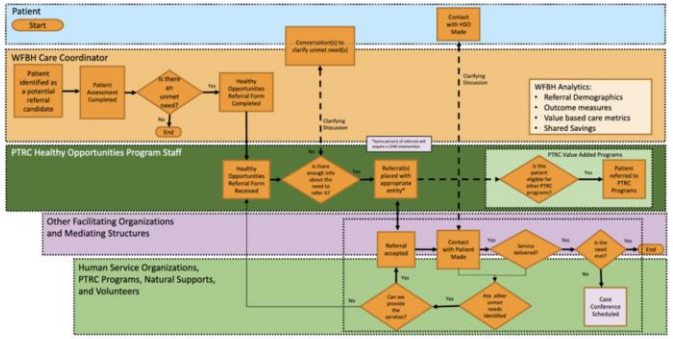
Stroke is the second leading cause of death and the third leading cause of death and disability worldwide[1]. A recent study concluded that incremental increases in the number of SDOH needs were independently associated with higher incident stroke risk in adults less than 75 years old[2]. Therefore, to optimize patient recovery, screening for social determinants of health (SDOH) needs should be integrated into hospital workflows, in conjunction with individualized care plans that address medical, rehabilitative, and SDOH needs.

To address SDOH needs in stroke patients, our team at Atrium Health Wake Forest Baptist (AHWFB) hospital has launched a patient-centered care model that integrates comprehensive SDOH screening with structured community referrals. We are partnering with the Piedmont Triad Regional Council Area Agency on Aging (PTRC-AAA), a community-based organization that supports aging populations across North Carolina. We are also collaborating with our Community Advisory Council for Stroke Care, which includes stroke survivors, caregivers, and community leaders.

Methods

- Study Design: feasibility study for a quality improvement initiative
- Targeted population: hospitalized stroke/TIA patients at AHWFB with the following SDOH needs
  - no insurance
  - transportation insecurity
  - food insecurity
  - housing insecurity
  - financial concerns
  - little to no caregiver support
  - needs assistance with paperwork
  - uncontrolled diabetes
  - substance abuse
  - recurrent strokes
  - uncontrolled blood pressure

Figure 1: Workflow



- EI and MA review the patient's chart including the SDOH questionnaire, clinical notes, to assess for any documented social needs. Furthermore, MA rounds with the inpatient stroke service team to identify patients with SDOH needs
- If a patient has a SDOH need, then MA or EI will discuss community health support services. If a patient is interested in additional support, then we will obtain verbal consent and send a referral to LQ at PTRC-AAA.
- LQ will reach out to the patient or caregiver to obtain additional SDOH needs.
- Following the intake phone call, LQ begins gathering information on community outreach resources that would be helpful for the patient and develops a plan to assist with patient's social needs. EL and AC supervise this work.
- EI schedules outpatient follow-up appointments with patients to follow-up on SDOH needs in stroke clinic.
- We have weekly team meetings to discuss patient's status and workflow optimization

Preliminary Results

- Between 07/01/25-08/31/25, we have obtained verbal consent from 17 patients with SDOH needs who were interested in a referral for community health support.
- LQ was able to contact 10 patients and provide community health support

LQ was able to provide the following services:

- provide education on medical insurance and disability assistance
- assist with filling out insurance forms, in-home aid forms
- assist with obtaining and delivering a walker
- assist with communicating patient needs to outpatient stroke team
- assist with creating post-discharge action plans for SDOH needs
- assist with obtaining medial and general transportation services
- follow up with patients to check on SDOH needs

Conclusion

Addressing SDOH needs in hospitalized stroke patients is essential for improving outcomes and reducing disparities. This initiative takes a systematic approach to identifying and addressing SDOH needs, particularly among rural and underserved populations. Early results have demonstrated a positive impact on patient care and recovery. As an innovative and scalable model, this project offers a promising solution to help close the gap in stroke disparities. With continued success, it has the potential to influence hospital workflows, inform clinical guidelines, and shape health policy at the institutional, state, and national levels.

References

1. Feigin VL, Brainin M, Norrving B, et al. World Stroke Organization: Global Stroke Fact Sheet 2025. International Journal of Stroke. 2025;20(2):132-144. doi:10.1177/17474930241308142
2. Reshetnyak E, Ntamatungiro M, Pinheiro LC, Howard VJ, Carson AP, Martin KD, Safford MM. Impact of Multiple Social Determinants of Health on Incident Stroke. Stroke. 2020 Aug;51(8):2445-2453. doi: 10.1161/STROKEAHA.120.028530. Epub 2020 Jul 16. PMID: 32673521; PMCID: PMC9264323.

Funding Sources

- American Academy of Neurology
- North Carolina Department of Health and Human Services: Paul Coverdell Acute Stroke Program Grant
- The Wilkes Medical Center Foundation
- The Winston-Salem Foundation

MOOSE PHARMACY: Community Pharmacy Coverdell Program

- Patient Care Process
  - Enhanced data collection
  - Stroke Risk Assessment
  - Social Needs Assessment
- Care Plan
- Social Drivers of Health Referrals
- Community Pharmacy & Continuity of Care
  - Community Health Workers: Delivery Drivers, Technicians, Cashiers
  - Health Screenings, Education, Case Management, Care Coordination & Navigation

UNC CHAPEL HILL: CREST Program

- Goals:
  - Optimize post-acute management
  - Follow-up appointments
  - Blood pressure and other stroke secondary prevention measures
  - Medication management
  - Addressing Social Drivers of Health (e.g., food and housing insecurity, substance use, transportation needs, access to healthcare)
- Objectives:
  - Develop a dashboard
  - Identify clinical, social and support service needs
  - Assess referrals and use of services through a bidirectional referral system
  - Expand the multidisciplinary stroke care team
  - Work with CSC to establish processes for improved care pathways and integrate measures and monitoring
  - Engage the community-based workforce

UNC REX: Hybrid Post-Stroke Clinic

- A hybrid stroke follow-up clinic to enhance access to & timeliness of post-discharge follow-up encounters for patients determined to be at high-risk for recurrent stroke
- Goal is to decrease wait time for stroke follow up post discharge to improve outcomes such as patient satisfaction, readmission rate, and LOS
  - Community Engagement Strategies
  - Bi-Directional Feedback
- Patient inclusion will target stroke patients with undiagnosed or uncontrolled hypertension

BARRIERS:

- Automation of processes (EMR speaking to referral processes)
- Establish a referral repository that is bi-directional
- Screening of SDoH consistent across departments

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2026 Meetings

Stay tuned for 2026 meeting schedule.

Stroke Coordinator Meetings on fourth Wednesdays at 2 PM will continue.

Justus-Warren Heart Disease and Stroke Prevention Task Force meeting Dec. 2 from 10:30-12:30 at the new DHHS Headquarters, 1915 Health Services Way/3905 Reedy Creek Road. Email Anna Bess if you are attending in person or need the virtual link.