**RFA #419**

**Paul Coverdell National Acute Stroke Program**

**Application Response Template**

**Section I – Activities (five (5) pages maximum for all activities), 20 points**

Applicants must explain how they will implement each of the activities below to reach the outcome.

# **REQUIRED Activity #1:** Make workflow changes and engage Electronic Health Record (EHR) vendors if needed to maximize use of EHR and Health Information Technology (HIT) to identify:

# Individuals who have experienced a stroke and those at highest risk of stroke due to undiagnosed or uncontrolled hypertension.

1. Healthcare disparities among those who have experienced a stroke and those at highest risk of stroke due to undiagnosed or uncontrolled hypertension.

**Outcome:**

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.

|  |
| --- |
| Applicant to describe how they will implement Activity #1: |

**REQUIRED** **Activity #2:** Use standardized procedures to identify clinical and social services and support needs (e.g., housing, transportation, food, childcare) for those who have experienced a stroke and those at 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 by:

1. Screening, monitoring, and assessing referral systems for clinical and social services and support needs.
2. Creating a repository of available social services and support resources.
3. Providing referrals for those patients identified as needing social services and support resources.
4. Creating a workflow for bidirectional feedback between the healthcare system and organizations providing social services and support resources.

**Outcome:**

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.

|  |
| --- |
| Applicant to describe how they will implement Activity #2: |

**REQUIRED Activity #3:** Use EHR, HIT, and program data to guide the development and implementation of quality improvement projects (e.g., Plan Do Study Act (PDSA) cycles, participant and partner feedback) to create referral systems that will include clinical, social services, and support needs. Quality improvement projects shall include:

1. A comprehensive protocol.
2. Recurrent and ongoing staff education.
3. Enhanced communication to mitigate delays and further improve care provided to patients presenting with stroke.

**Outcome:**

Increased use of metrics from EHR/HIT and program data to guide quality improvement activities.

|  |
| --- |
| Applicant to describe how they will implement Activity #3: |

**REQUIRED Activity #4:** Monitor and assess EHR and Get with the Guidelines®-Stroke data within priority populations across systems of care.

**Outcome:**

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 unmanaged hypertension.

|  |
| --- |
| Applicant to describe how they will implement Activity #4: |

**REQUIRED Activity #5:** Build stroke care teams that work across the continuum of care (from the onset of stroke symptoms through rehabilitation and recovery) for those who have experienced a stroke and those at highest risk of stroke. The stroke care teams shall:

1. Include both clinical and community-based entities and individuals (e.g., emergency medical services, emergency departments, in-patient care, pharmacists, social workers, post-discharge care, community health workers, patient navigators).
2. Identify patient’s social services and support needs (e.g., housing, transportation, food, childcare) and refer to needed services and supports.
3. Use standardized procedures to track and assess referrals and use of those services and resources.

**Outcome:**

Increased number of individuals with identified social services and support needs referred to those services using standardized procedures among the care team, to include both clinical and community-based entities and individuals, across the stroke continuum of care.

|  |
| --- |
| Applicant to describe how they will implement Activity #5: |

**REQUIRED Activity #6:** Make changes to the stroke continuum of care that will improve the efficiency, quality, and transition of care among the stroke care team (e.g., emergency medical services, emergency departments, in-patient care, pharmacies, social workers, post-discharge care, community health workers, patient navigators) through systematic quality improvement methods and interventions.

**Outcome:**

Expanded collection and use of data elements across the continuum of care to improve efficiency and quality of care among the care team, to include both clinical and community-based entities and individuals.

|  |
| --- |
| Applicant to describe how they will implement Activity #6: |

**REQUIRED Activity #7:** Develop and implement a plan to improve communication, coordination, and collaboration among the stroke care team ensuring individuals who have experienced a stroke are included in the development.

**Outcome:**

Increased number of individuals served by clinics, health systems, and in community settings that use care teams comprised of both clinical and community expertise to prevent stroke.

|  |
| --- |
| Applicant to describe how they will implement Activity #7: |

**REQUIRED Activity #8:** Facilitate the engagement of the community-based workforce (e.g., community health workers, community health representatives, social workers, patient navigators) in managing community resources and clinical services that support those who have experienced a stroke and those at highest risk of stroke across the continuum of care to improve outcomes by:

1. Assessing community needs and assets (e.g., surveys, focus groups, interviews with stakeholders such as those who have experienced a stroke, caregivers, healthcare providers, community leaders).
2. Leveraging technology to enhance communication among community-based workers and healthcare providers. This can include telehealth platforms for remote consultations, mobile apps for tracking health metrics, and online resources for education and support.

**Outcome:**

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 risk of stroke.

|  |
| --- |
| Applicant to describe how they will implement Activity #8: |

**REQUIRED** **Activity #9:** Participate in the quarterly Cardiovascular Health Learning Collaborative hosted by CCCPH to learn from other organizations and share successes and challenges.

**Outcome:**

Increased knowledge of stroke systems of care and best practices to improve patients’ health outcomes.

|  |
| --- |
| Applicant to describe how they will implement Activity #9: |

**Section II– Strengths and Needs (three (3) pages maximum), 20 points**

|  |
| --- |
| 1. Applicant to specify and describe the county(ies) or area(s) in which they will work. Work within all counties is acceptable, however **preference may be given to applicants that focus on counties with the** [**highest rate of heart disease**](https://nciom.org/nc-health-data/map/?Health_Data_Email__health_map_email_)**:**
 |
| 1. Applicant to describe issues (e.g., health disparities, gaps in services or access, concerns expressed by the community) in the county(ies) or area(s) that will be addressed by the implementation of activities, and how the issues were identified:
 |
| 1. Applicant to describe community assets (e.g., partnerships, community groups, plans, volunteers, funding, ongoing initiatives) that will be leveraged to support implementation of the activities:
 |

**Section III – Organizational Capacity (three (3) pages maximum), 20 points**

|  |
| --- |
| 1. Applicant to provide evidence that their organization has the capacity to implement the activities:
 |
| 1. Applicant to describe their experience collecting, reporting and/or analyzing data to evaluate activities like those required in this RFA:
 |
| 1. Applicant to describe the individuals, agencies, and/or organizations that they will partner with to implement the activities and their role in their proposed implementation. You must include a Letter of Commitment from each partner described:
 |
| 1. Applicant to describe plans to engage other key individuals, agencies, and organizations with implementation of their activities, and how those entities will fill roles not filled by the partners listed in Section III.3 above:
 |

**Section IV – Health Equity (two (2) pages maximum), 20 points**

|  |
| --- |
| 1. Applicant to describe how they have and/or how they will engage the community (e.g., individuals who have experienced a stroke, community health workers, pharmacists, patient navigators, social workers) to assess (e.g., identify assets, needs, interests, readiness), plan, and implement the activities:
 |
| 1. Applicant to describe work that is occurring in their selected county/area to impact determinants of health (i.e., conditions in the environment in which people are born, live, learn, work, play, and worship; and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks) and how this work will support/increase the impact of their proposed activities:
 |

**Section V - Project Budget, 10 points**

Applicants must complete two (2) budget narratives (one (1) for each budget period) using the Budget Templates located [here](https://www.communityclinicalconnections.com/paul-coverdell-national-acute-stroke-program-rfa/).

A narrative justification must be included for every expense listed in the budget. Each justification should show how the amount on the line-item budget was calculated, and it should clearly state how the expense relates to the project.

The budget narratives must be submitted in an .xls. or .xlsx format. **See page 17 of the RFA for more information.**

**Section VI – Letters of Commitment (no limit), 10 points**

Letters of commitment should be included from any agency or community organization integral to the success or implementation of the proposed activities. Letters should describe the agency/community organization’s contribution to implementation of proposed activities. **The letters can be attached to this Application Response Template or included as a separate attachment. If including the letters as an attachment, please merge all letters into one PDF.**