The Ohio Coverdell Stroke Quality Improvement Change Package

Reducing Stroke Risk Through Continuity of Care

2026

Department of Health
Ohio Coverdell Stroke Quality Improvement Project

OHIO COLLEGES OF MEDICINE
GOVERNMENT RESOURCE CENTER

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Executive Summary

Stroke remains a leading cause of disability and death in the United States and Ohio, with prevalence increasing in recent years despite advances in care.[1]

There has been a rise in stroke prevalence nationally, including in Ohio, reflecting persistent burdens of uncontrolled hypertension and other cardiovascular risk factors.[1,2] Unmet health-related social needs (HRSN) such as limited access to care, inadequate insurance, transportation barriers, and financial instability contribute to poor hypertension control and hinder recovery after stroke.[3,4,5] Addressing social needs alongside clinical care is essential to improving stroke prevention and outcomes.

This change package provides practical, testable change ideas for hospitals and primary care practices participating in the Ohio Coverdell Stroke Quality Improvement Project (QIP). It summarizes the evidence base, clarifies key drivers, and offers starting points for small-scale tests of change using Plan-Do-Study-Act (PDSA) cycles to improve continuity of care and reduce stroke risk.

Background

Stroke continues to pose a substantial public health burden in the United States with recent national surveillance data estimating that approximately 3.3–3.4% of U.S. adults have a history of stroke.[6] Each year, an estimated 795,000 people experience a new or recurrent stroke, including roughly 610,000 first-ever events and 185,000 recurrent events, with ischemic strokes accounting for the majority of cases.[6] Although age-standardized stroke rates declined in earlier decades, more recent data shows overall stroke prevalence increased by 7.8% from 2011–2013 to 2020–2022, with notable increases among adults aged 18–64 years and across multiple racial and ethnic groups.[6] These trends underscore the growing importance of sustained prevention efforts, particularly those targeting modifiable risk factors such as hypertension, diabetes, obesity, smoking, and physical inactivity.

In Ohio, the burden of stroke is particularly pronounced and has worsened over the past decade.[1] According to the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System data summarized in the 2024 *Morbidity and Mortality Weekly Report*, Ohio experienced the largest percentage increase in stroke prevalence of any U.S. state, with a 20.9% rise when comparing 2011–2013 with 2020–2022, substantially exceeding the national increase of 7.8%.[1] Stroke incidence in Ohio reflects broader patterns of cardiovascular risk in the state, where high blood pressure, diabetes, obesity, and smoking remain common and contribute substantially to stroke risk.[2] Stroke is a leading cause of death statewide, reinforcing the need for coordinated prevention, early detection, and quality improvement initiatives to reduce stroke incidence and improve outcomes for Ohio residents.[2]

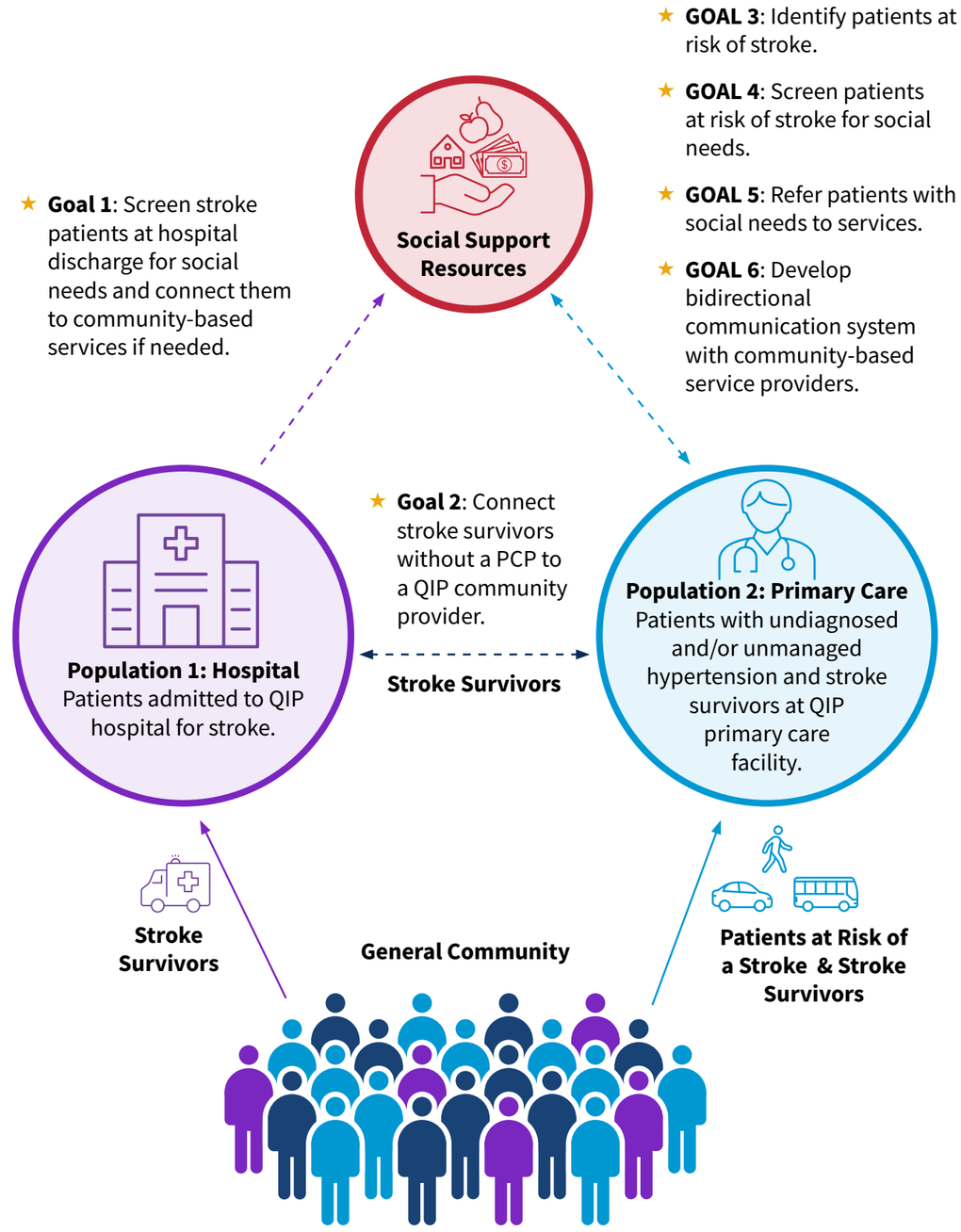
Unmet social needs influence stroke risk and recovery across the care continuum. Among individuals with hypertension, gaps in diagnosis, treatment, and blood pressure control are strongly associated with socioeconomic factors such as limited access to care, lower income, and inadequate insurance coverage, which increase the likelihood of unmanaged hypertension and subsequent stroke.[3] HRSN also shape stroke outcomes, influencing engagement in secondary prevention and contributing to persistent disparities in morbidity and mortality.[5] Following a stroke, many patients continue to experience unmet social needs related to finances, employment, transportation, and access to social services.[5] These unmet needs are associated with decreased quality of life, greater disability, and increased caregiver burden, underscoring the importance of integrating social needs screening and referral into both stroke prevention and post-acute care.[4,5]

Coverdell Stroke Quality Improvement Project

The Ohio Coverdell Stroke Quality Improvement Project (QIP) strengthens stroke care and prevention by improving coordination between certified acute stroke hospitals and primary care settings, with a focus on addressing both clinical and social needs. The QIP targets patients who have experienced a stroke, as well as patients at high risk of stroke due to undiagnosed or uncontrolled hypertension. In the hospital setting, the project supports post-acute smooth transitions of care by assessing clinical and social needs and improving post-discharge care and support. In primary care, the QIP emphasizes identification and management of hypertension and other stroke risk factors, assessment of social needs, referral to community resources, and tracking referral utilization. Closed-loop referrals from hospital providers to primary care providers (PCPs), and PCPs to community providers will be the focus of the project (see Image 1). Specific QIP activities include:

- Identify patients with undiagnosed hypertension and uncontrolled blood pressure in primary care.
- Assess patients' clinical and social needs.
- Refer patients with social needs to appropriate resources.
- Determine patient utilization of the referral / referral tracking.
- Bidirectional tracking of patients who are admitted for a stroke (either first or repeat stroke).
- Tracking of patients admitted/readmitted to the QIP hospital facility due to stroke.

The image below illustrates the primary goals and scope of this QIP:



How to Use This Change Package

This change package is designed as a practical toolkit to support hospitals and PCPs participating in the Ohio Coverdell Stroke QIP. It translates the Key Driver Diagram into actionable strategies that teams can adapt to their local context.

The change ideas included here are not intended to be implemented all at once. Instead, teams are encouraged to:

- Identify gaps in current workflows.
- Select one or two change ideas to test.
- Use small-scale tests of change (e.g., PDSA cycles).
- Adapt interventions to fit site-specific resources and constraints.

While workflows may differ across hospitals and primary care facilities, the core principles, aims, and measures are shared across participating sites to support learning, comparability, and improvement at scale.

Theory of Change and Key Assumptions

This change package is grounded in the following assumptions:

1. A significant proportion of uncontrolled stroke risk factors, including hypertension, are influenced by unmet social needs such as limited access to care, transportation barriers, medication affordability, and lack of primary care follow up.
2. These barriers are not always systematically identified and addressed during hospitalizations or ambulatory visits.
3. When social needs are identified but not paired with clear referral pathways and follow-up, patients are unlikely to receive services.
4. Standardizing processes, not outcomes, across the stroke continuum of care can reduce variation, improve reliability, and strengthen transitions of care.
5. Improving screening, referral, documentation, and follow up will increase the likelihood that patients receive appropriate clinical and social support, improving risk factor control and thereby reducing future stroke risk.

The change ideas in this package are designed to test and strengthen these assumptions through iterative quality improvement (QI). Unlike traditional research, which seeks to generate generalizable knowledge through rigorous study designs, QI methodologies focus on rapid, iterative testing within real-world settings to enhance processes and outcomes. QI emphasizes practical change and adaptation to local context rather than controlled experimentation.

Key Drivers

Key Driver 1: Standardize Care Across the Stroke Continuum of Care

Key Driver 1 focuses on creating consistent, reliable processes for identifying stroke risk factors and social needs and ensuring patients receive the right care in a timely manner across settings.

How to Operationalize Key Driver 1

Universal HRSN Screening Across Settings

Teams should implement a standardized approach to social needs screening at defined points in care, recognizing that the exact workflow may vary by site.

In hospital settings, social needs screenings may occur at:

- Admission.
- During the inpatient stay.
- Discharge.

In primary care settings, social needs screenings often occur at:

- Intake.
- Annual visits.

Regardless of when the screening happens, it is important that the process is standardized and patient information is documented/charted in the appropriate electronic health record (EHR) fields.

Why This Matters

Stroke survivors frequently experience fragmented care during transitions between hospital and primary care settings. Inconsistent discharge processes, unclear follow-up responsibility, and lack of standardized screening may contribute to missed opportunities for primary and secondary prevention.

Research shows that structured transition of care processes can reduce hospital readmission rates, while emerging literature suggests integrating HRSN screening may improve discharge planning and recovery.[7,8]

Practical steps teams can test include:

- Embedding a validated screening tool into the EHR.
- Defining who administers the screen (e.g., nurse, medical assistants, social worker).
- Establishing processes to ensure screening is fully completed.
- Creating a clear escalation pathway for positive screens.

Teams should anticipate that screening alone will not improve outcomes unless paired with referral and follow-up workflows (Key Driver 2).

Standardized Stroke Discharge and Transition of Care Processes

Each participating hospital should develop a site-specific but standardized discharge process for stroke patients. Rather than requiring identical discharge summaries across sites, this project emphasizes consistent core elements, including:

- Stroke diagnosis and etiology.
- Hospital course summary.
- Outstanding tests.
- Level of functioning at discharge (initial National Institutes of Health Stroke Scale (NIHSS) vs discharge NIHSS, Rankin Score).
- Medication changes and secondary prevention plan.
- Blood pressure targets.
- Pending or abnormal results necessitating PCP review and follow-up.
- Any barriers (HRSN) that interfere with secondary prevention plans (transportation, lack of insurance, etc.).
- Scheduled follow-up appointments and referrals.

Small tests, such as piloting a checklist on one unit, can help refine the process before broader rollout.

Key Driver 2: Partnerships and Referral Pathways

Key Driver 2 focuses on strengthening connections across hospitals, primary care, clinical services, and community-based organizations so that social needs identified through screening leads reliably to services. This includes developing clear referral pathways and defining shared processes for referral and follow-up across partners.[9,10,11]

How to Operationalize Key Driver 2

Community Resource Guides and Platforms

Rather than building new tools, teams are encouraged to incorporate existing community resource platforms into their workflow. These platforms can reduce staff burden by providing a directory of statewide resources to facilitate attainable referrals for the patients.

Practical tests may include:

- Piloting a single social needs referral platform (e.g., FindHelp, Unite Us) with one patient population.
- Identifying a clear owner responsible for maintaining access and training to the platform.
- Integrating links into the EHR or discharge workflow.

Why This Matters

Identifying social needs does not improve care unless patients are successfully connected to services. Referral processes are often informal, inconsistently documented, or dependent on individual staff knowledge.

Defined partnerships and referral pathways will increase the likelihood that patients receive support and allow teams to measure closed looped referrals.

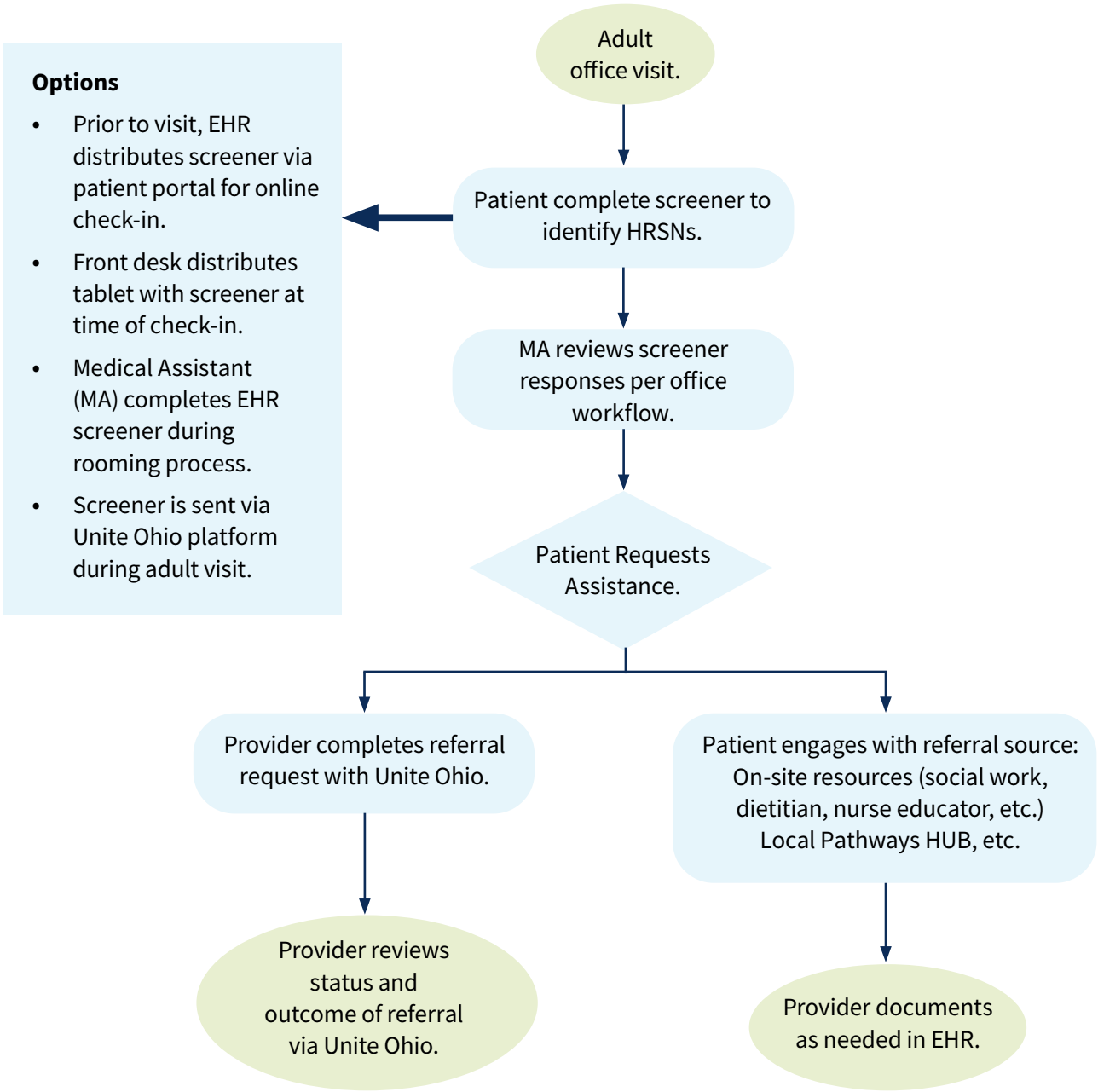
Teams should define the referral workflow, including:

- Who initiates the referral.
- How the referral is documented.
- Referral follow up tracking.
    - If there is not a way to track follow-up, identify test of change to develop that process.

Importantly, referral workflows should reflect what is within the site's control. For example, while teams may not control community capacity, they can standardize documentation and

follow-up attempts. The following example workflow aims to link survivors of stroke or those at high risk of stroke to community lifestyle change programs and other resources. Consider using a referral platform to facilitate these referrals and continue using your EHR to its fullest potential for screening and referral options.

Community Referrals Workflow



Key Driver 3: Reliable Documentation and Data Tracking

Key Driver 3 focuses on ensuring screening, referral, and follow-up activities are consistently documented and measurable so teams can track progress, identify gaps, and guide ongoing quality improvement work. This includes using EHR and reporting infrastructure to support population identification, end-to-end referral tracking, and QI learning.[8,9,11] Data dashboards provided through this QIP will allow sites to stratify data based on populations of focus.

How to Operationalize Key Driver 3

End-to-end Referral Tracking

End-to-end tracking refers to documenting each step of the process: Screen → Refer → Access services.

Teams should work toward capturing:

- Whether screening occurred.
- Whether a referral was made.
- Whether the patient was able to access services.

Why This Matters

Accurate and consistent documentation enables care teams to identify gaps, evaluate outcomes, and determine the need for QI interventions over time.

Early tests may focus only on documenting referral attempts. Over time, teams can expand tracking outcomes as systems mature.

Using Data for Learning, Not Judgment

Data collected through this project is intended to support learning and improvement, not to penalize sites. Teams should review data regularly to:

- Identify drop-off points.
- Understand workflow challenges.
- Inform PDSA cycles.

Even incomplete data may provide valuable insights when reviewed consistently.

Getting Started: Suggested First Tests of Change

Teams new to this work may consider starting with one of the following:

- Piloting HRSN screening on one hospital unit or one clinic day in primary care.
- Standardizing one element of the stroke discharge summary.
- Tracking referrals for a single social need category.

Small, focused tests help teams build confidence and adapt interventions before scaling.

Coverdell Stroke QIP Key Driver Diagram

Levels of Reliability (LOR)
1. Basic Reliability
2. Standard Reliability
3. High Reliability

SMART AIM

- By May 2027, increase the % of stroke patients or those at risk of a stroke from X% to X% that are **screened** for HRSN at hospital* discharge and in primary care.
- By May 2027, increase the % of stroke patients or those at risk of a stroke with positive HRSN from x% to x% that have a **documented care plan** for social support services.
- By May 2027, increase the % of stroke patients or those at risk of a stroke with HRSN from x% to x% that r**eceive social support services**.
- By May 2027, x% of patients that experience a stroke will receive a PCP referral.

Global AIM

To improve the quality of stroke prevention and care for those at highest risk of stroke in Ohio.

Population

Adult patients who have experienced a stroke and those with uncontrolled or undiagnosed hypertension in Franklin, Hamilton, Montgomery, and Lucas counties.

KEY DRIVERS

Standardize Care Across the Stroke Continuum of Care

Partnership and Referral Pathways

Reliable Documentation and Data Tracking

1ST TIER INTERVENTIONS

- Integrate universal HRSN screening into workflows.
- Standardize stroke discharge and transition-of-care processes.
- Establish clear referral pathways across hospital and PCP providers and community-based workers (e.g., Community Health Workers (CHWs)).
- Utilize a statewide or regional community resource guide.
- Define multidisciplinary team roles for referral and follow-up.
- Use data to guide QI efforts to identify gaps, delays, and inefficiencies.
- Leverage EHRs, and Get With The Guidelines®- Stroke, and project data dashboard to identify populations of focus.
- Establish end-to-end referral tracking (screen →refer → access care).

2ND TIER INTERVENTIONS

Screening & Intake
- Turn on/develop HRSN screening tools in the EHR (LOR=2).
- Train staff on stroke and HRSN screening workflows (LOR=1).
- Incorporate HRSN screening into hospital admission and discharge workflows (hospital) (LOR=2).
- Distribute HRSN screening materials at PCP registration (PCP) (LOR=1).

Discharge & Transition of Care (hospital-level interventions)
- Use stroke-specific discharge checklist (LOR=1).
- Provide medication scripts and fill meds before discharge (LOR=2).
- Develop after-hospital care plans and handoff to PCP (including standardized discharge summary) (LOR=2).
- Assign and schedule patients without a PCP for an appointment to a Coverdell QIP PCP (LOR=2).
- Create standardized hospital-to-primary care transition process (LOR=2).
- Create standardized hospital-to-clinical services transition process (LOR=2).

Referral & Follow-Up
- Create referral workflows after positive HRSN screens (LOR=2).
- Create referral order sets in the EHR (LOR=2).
- Develop EHR prompts for social service referrals (LOR=2).
- Track referral completion and service receipt (LOR=2).
- Use shared decision-making in care planning (LOR=1).
- Utilize social needs referral platform to find community resources and facilitate closed loop referrals (LOR=3).

Documentation, Data & QI Infrastructure
- Integrate EHR (PCP) and Get With The Guidelines®-Stroke (hospital) revisions to document screening and referrals (LOR=2)
- Utilize EHR flags and notifications for at-risk patients (LOR=2)
- Collect visit-level data and submit monthly reports (LOR=1)
- Conduct pre- and post-QI surveys (LOR=1)
- Identify clinical champion and multidisciplinary QI team (LOR=1)
- Use PDSA cycles to refine workflows (LOR=1)
- Standardization of HRSN Z codes (LOR=2)

**Hospital setting will focus on stroke patients only; PCP setting will focus on patients at risk of stroke due to uncontrolled and undiagnosed hypertension and those with stroke history.*

Interventions

The interventions listed in this change package are actionable change ideas that teams can test and implement to operationalize the Key Driver Diagram. **While 1st tier interventions describe what must be in place to achieve each key driver, the 2nd tier interventions describe how teams can build, standardize, and sustain those capabilities in the daily workflow.**

Importantly, the 2nd tier interventions are designed to cross-cut multiple 1st tier interventions (and therefore reinforce multiple key drivers). For example, an EHR build and staff training support both standardized screening and reliable documentation; referral workflows, order sets, and closed-loop tracking strengthen partnerships while also improving measurement and reliability. Teams may select and adapt 2nd tier interventions based on local context (hospital vs. PCP), existing infrastructure, and current gaps, and then use iterative testing (e.g., PDSA cycles) to improve reliability over time.

1st Tier Interventions

Key Driver 1: Standardized Care Across Stroke Continuum of Care

- Integrate universal HRSN screening into workflows.
- Standardize stroke discharge and transition of care processes.

Key Driver 2: Partnerships and Referral Pathways

- Establish clear referral pathways across hospital and PCP providers and community-based workers (e.g., CHWs).
- Utilize a statewide or regional community resource guide.
- Define multidisciplinary team roles for referral and follow-up.

Key Driver 3: Reliable Documentation and Data Tracking

- Use data to guide QI efforts to identify gaps, delays, and inefficiencies.
- Leverage EHRs, Get With The Guidelines®-Stroke, and project data dashboard to identify populations of focus.
- Establish end-to-end referral tracking (Screen → Refer → Access care).

2nd Tier Interventions

Screening and Intake

- Turn on/develop HRSN screening tools in the EHR.
- Train staff on stroke and HRSN screening workflows.
- Incorporate HRSN screening into hospital admission and discharge workflows (hospital).
- Distribute HRSN screening materials at PCP registration (PCP).

Discharge & Transition of Care (hospital-level interventions)

- Use stroke-specific discharge checklist.
- Provide medication scripts and fill meds before discharge.
- Develop after-hospital care plans and handoff to PCP (including standardized discharge summary).
- Assign and schedule patients without a PCP for an appointment to a Coverdell QIP PCP.
- Create standardized hospital-to-primary care transition process.
- Create standardized hospital-to-clinical services transition process.

Referral & Follow-up

- Institute referral workflows after positive HRSN screens.
- Create referral order sets in the EHR.
- Develop EHR prompts for social service referrals.
- Track referral completion and service receipt.
- Use shared decision-making in care planning.
- Utilize social needs referral platform to find community resources and facilitate closed loop referrals.

Documentation, Data & QI Infrastructure

- Integrate EHR (PCP) and Get With The Guidelines®-Stroke (hospital) revisions to document screening and referrals.
- Utilize EHR flags and notifications for at-risk patients.
- Collect visit-level data and submit monthly reports.
- Conduct pre- and post-QI surveys.
- Identify clinical champion and multidisciplinary QI team.
- Use PDSA cycles to refine workflows.
- Standardization of HRSN Z codes.

Appendices

Appendix A: Model for Improvement

The Model for Improvement developed by Associates in Process Improvement[12] provides a simple framework for healthcare professionals to utilize as they provide quality healthcare to patients. Through a series of small, measurable, rapid changes in processes, QI methodology can lead to improved processes with reduced variation, improving patient outcomes and improving healthcare clinics and systems.[13]

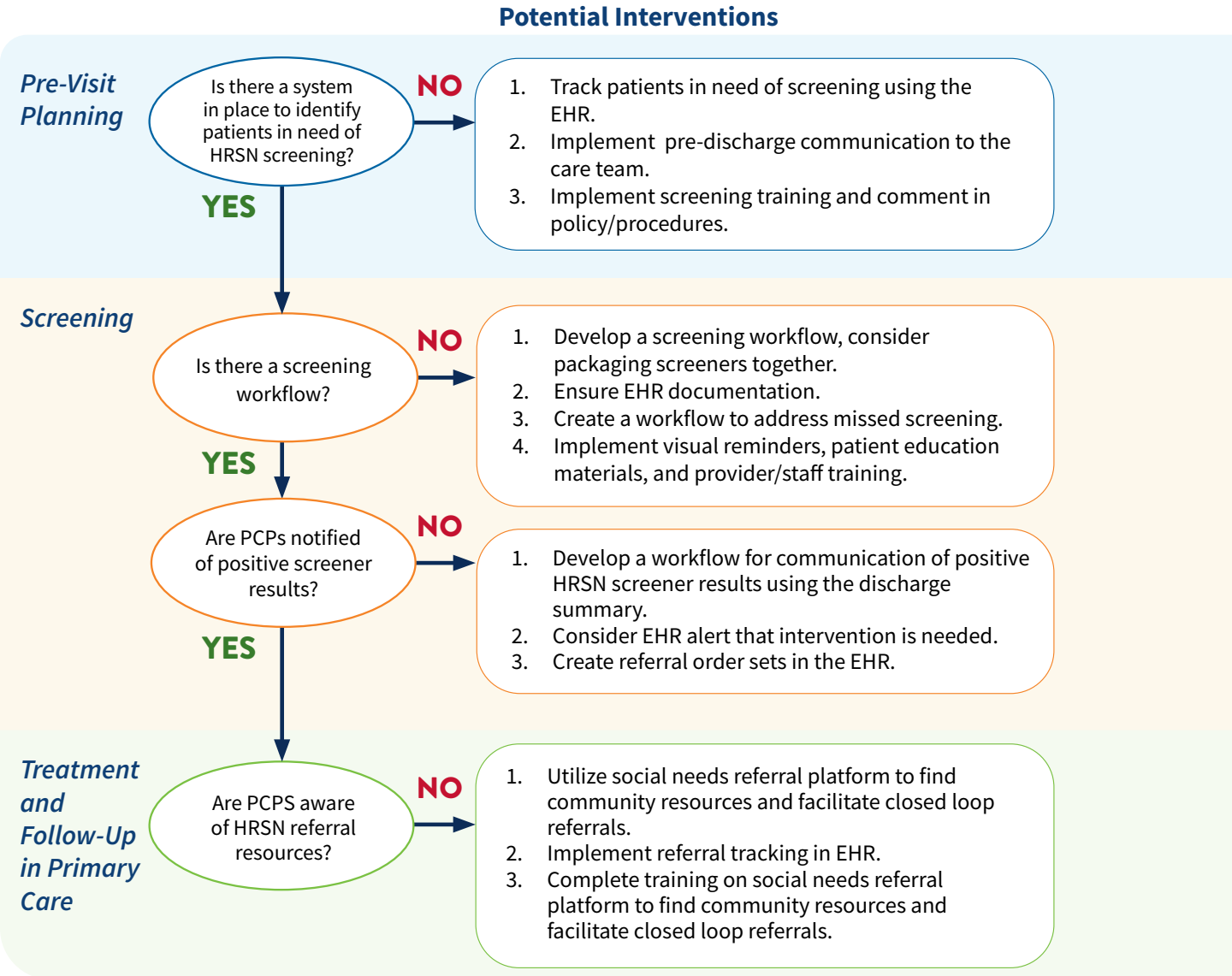
Components of a successful QI project include:

- A multidisciplinary team, including a clinical champion and leadership support.
- Access and support for bi-weekly data submissions.
- Dedicated time to actively engage in QI science methods, including Plan-Do-Study-Act (PDSA) cycles.
- Regular participation in peer-to-peer sharing and coaching meetings.
- Process to share and spread lessons learned.

Plan-Do-Study-Act Cycles

Quality improvement science emphasizes starting small with initial tests of change conducted on a small scale (e.g., one patient for one day) to evaluate impact. Depending on the results, the intervention may be adopted as-is, adapted for subsequent PDSA cycles, or replaced with a new change idea if the current approach proves ineffective.

Appendix B: Getting Started - How to prioritize interventions



Appendix C: HRSN Billing and Coding

Accurate documentation and coding of HRSN supports continuity across the stroke care continuum by making social needs visible to the entire care team, enabling referral tracking, and allowing sites to measure gaps in screening-to-service workflows.[14] When possible, HRSN screening results should be captured in structured EHR fields (rather than free-text alone) so information can be reported reliably and used for panel-level quality improvement. Documentation should clearly identify the specific social need, its impact on care (e.g., medication adherence, ability to attend follow-up), and the actions taken (e.g., patient education, referral placed, follow-up plan).

To standardize capture of HRSN in the medical record and claims data, practices should use ICD-10-CM "Z" codes (Z55–Z65) to document socioeconomic and psychosocial circumstances (e.g., Z55- Problems related to education and literacy; Z56- Problems related to employment and unemployment; Z59- Problems related to social environment, etc.).[15,15] These codes are not the primary medical diagnosis for the encounter, but they can be added as supplemental diagnoses to reflect barriers that influence health outcomes and care planning. Incorporating Z-code documentation into existing workflows (e.g., visit intake, discharge planning, or social work assessment) can reduce missed opportunities and support consistent data capture across hospital and ambulatory settings.[15,16] Finally, aligning documentation with referral processes (screen → refer → Access) strengthens closed-loop tracking and helps teams identify potential barriers for completion. A full list of Z codes can be found in the Screening for Social Determinants of Health in Daily Practice article.

Appendix D: Guidance for Discussing Social Needs with Patients

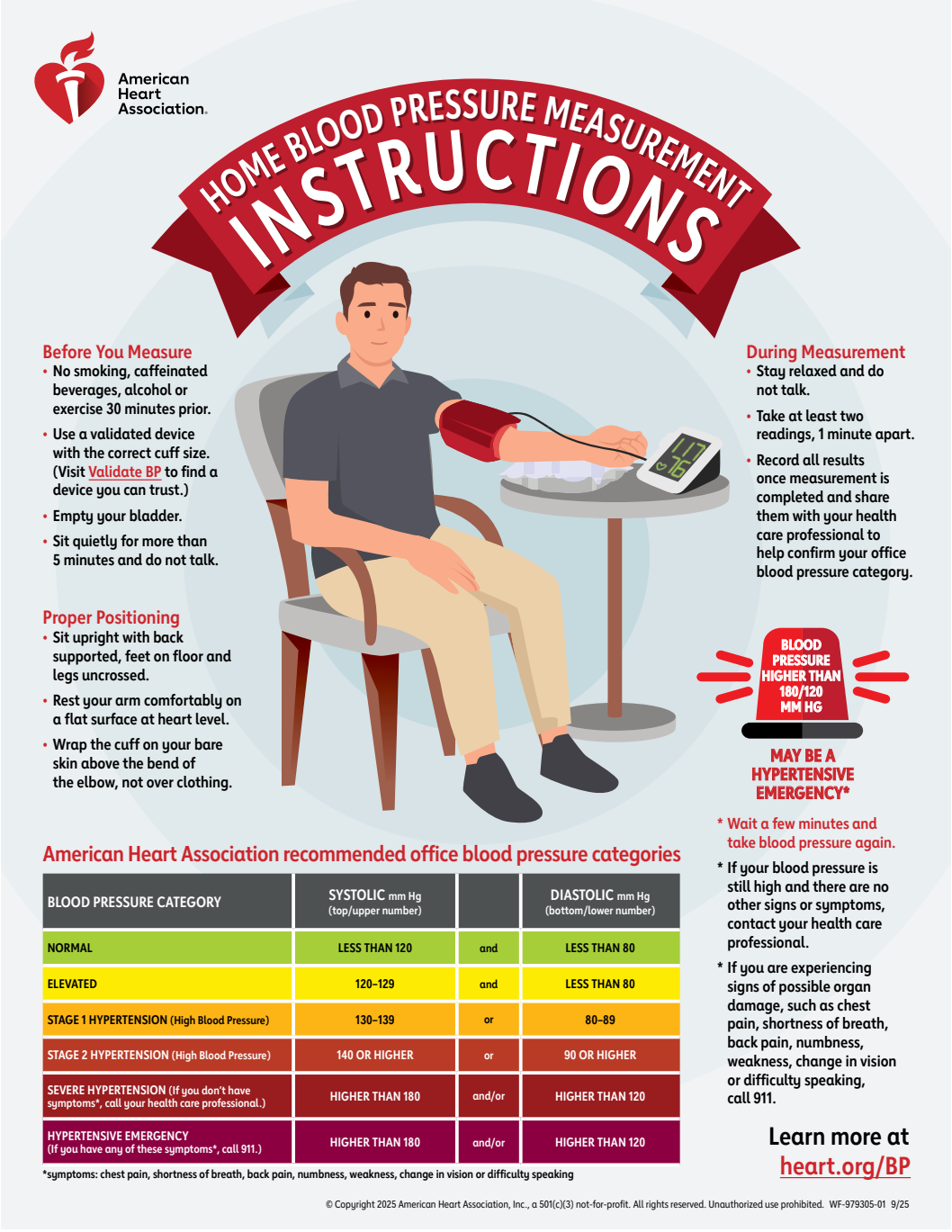
For those unfamiliar or uncomfortable with HRSN screening, there are available resources to help facilitate and frame these discussions. Guidance can be found:

The time is now: Fostering relationship-centered discussions about patients' social determinants of health
Patient Education and Counseling

Screening tools to address social determinants of health in the United States: A systematic review
Journal of Clinical and Translational Science

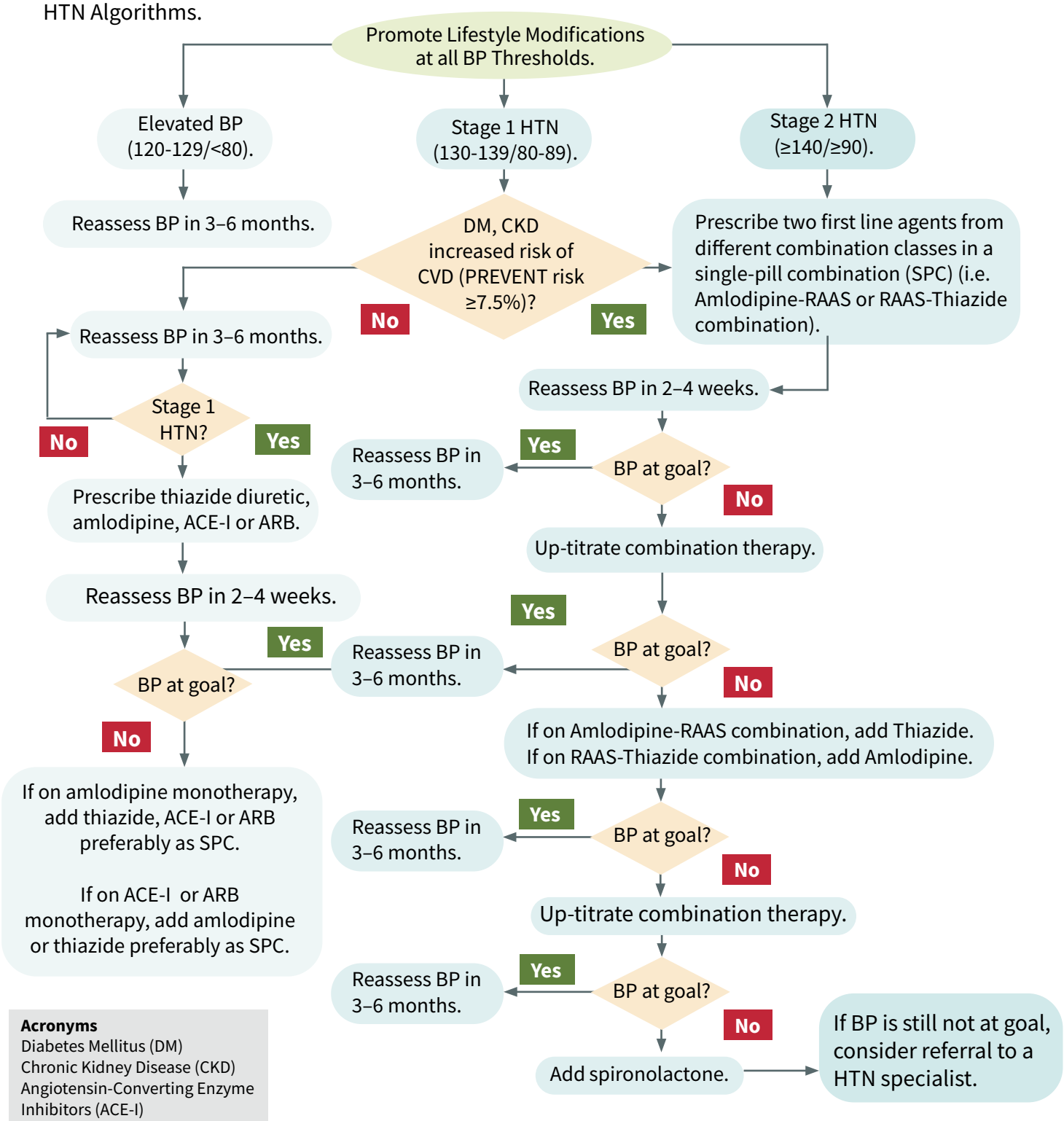
Appendix E: Blood Pressure Measurement Instructions

The American Heart Association provides guidance for patients to monitor their blood pressure including the following visual aid.[16] Providers can share this resources with patients to promote accurate home monitoring. If your practice is interested in incorporating a home blood pressure monitoring program at your site, please reach out to ODH (Ashton.Thacker@odh.ohio.gov) for additional tools and guidance.



Appendix F: Hypertension (HNT) Algorithm from the Achieving Cardiovascular Excellence Quality Improvement Project

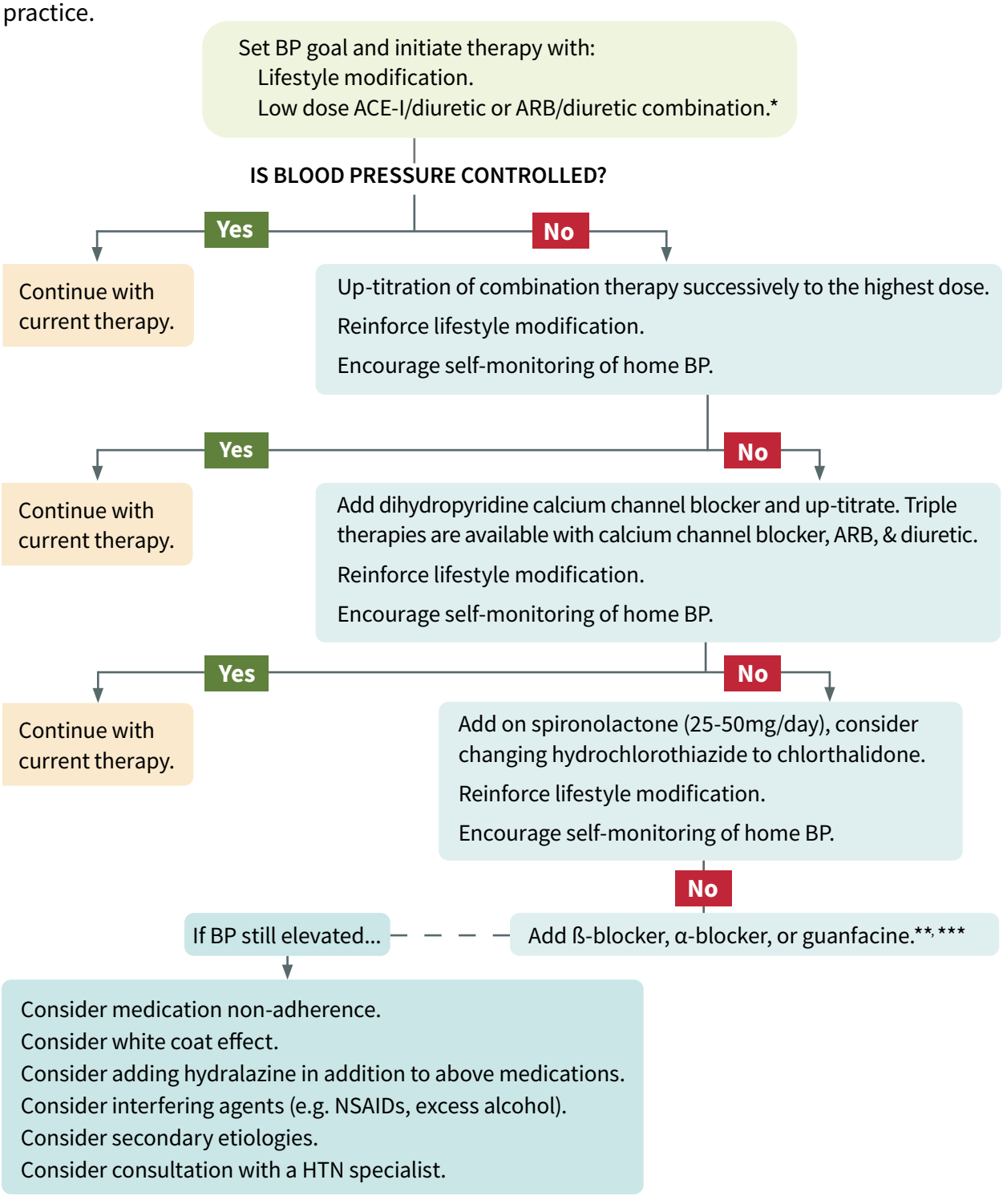
HTN Algorithm: Adapted from AHA/ACC 2025 Blood Pressure (BP) Guidelines and Cardi-OH HTN Algorithms.



Acronyms
Diabetes Mellitus (DM)
Chronic Kidney Disease (CKD)
Angiotensin-Converting Enzyme Inhibitors (ACE-I)

Appendix G: Classic HTN Drug Treatment Guidelines[17]

Use of a validated treatment algorithm will improve blood pressure control within your practice.



*If pregnant or pregnancy potential, avoid using ACE-I or ARB or spironolactone.
**Avoid starting a beta blocker if pulse <70 or on a non-dihydropyridine calcium channel blocker.
***Guanfacine has similar mechanism of action as clonidine and is once daily instead of three times a day.

Appendix H: BE FAST

BE FAST is a tool designed to help identify the signs of stroke quickly and accurately. Each letter stands for a specific symptom.[18]

Appendix I: Life's Essential 8 (American Heart Association)

The American Heart Association's Life's Essential 8 are eight core measures of cardiovascular health that can help lower risk of heart disease and stroke.[19] They include four health behaviors (nutrition, physical activity, avoiding nicotine exposure, and getting healthy sleep) and four health factors (healthy body weight, blood lipids/cholesterol, blood glucose, and blood pressure).[20] The American Heart Association provides robust, ready-to-use materials for both patients and providers, including plain-language handouts and fact sheets, as well as assessment tools (e.g., My Life Check) to support education, goal-setting, and follow-up. The AHA website goes in-depth into each of these topics.

1. Eat better.
2. Be more active.
3. Quit tobacco / avoid nicotine exposure (including secondhand smoke).
4. Get healthy sleep.
5. Manage weight.
6. Control cholesterol.
7. Manage blood sugar.
8. Manage blood pressure.

Learn more by visiting the Life's Essential 8 webpage.

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