www.tristatestrokenetwork.org

Tri-State Stroke Network Strategic Plan 2006-2007

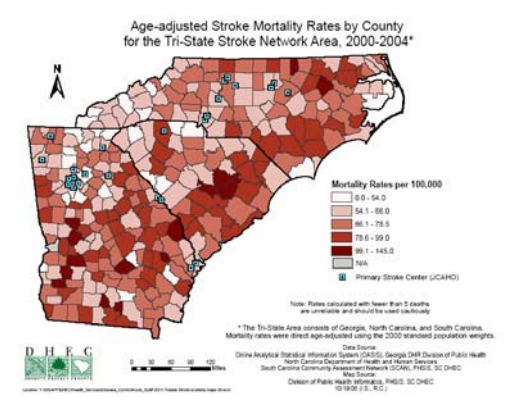
I. Executive Summary

The Tri-State Stroke Network (TSSN) functions as a "community of practice" that allows public health leaders and experts in stroke prevention and treatment to connect, share current ideas and knowledge, generate resources and foster relationships with stakeholders from North Carolina, South Carolina, and Georgia.[1] Members cross organizational and state government boundaries to share information and collaborate on projects. A core function of the Network is to enhance prevention efforts of state heart disease and prevention programs in NC, SC, and GA.

Over the past six years, the Network members collaborated to plan and implement annual Data Summits. These conferences offer participants an opportunity to learn about the latest stroke related data across the entire stroke system of care (prevention to rehabilitation). Committees work on specific projects such as the Facilities Survey where hospitals in South Carolina and Georgia reported on their capacity to treat stroke. These were based on the survey instrument from previous surveys in North Carolina.[2] Additional questions on JCAHO certification were included in the TSSN SC & GA surveys. The Epi. & Data Committee then generated GIS maps of the survey results and placed them on the TSSN website. Currently, this committee is creating GIS maps that show geographic disparities between stroke mortality and stroke certified centers. Other committees are currently working on projects such as the Health Disparities Survey and the Work-site Pilot Project. These are explained in more detail in the following sections.

II. Background

A. The Region



North Carolina, South Carolina, and Georgia are part of the "Stroke Belt" - an 8-12 state region (typically including Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and often including Florida, Indiana, Kentucky, Virginia and Washington D.C. as well). These states have had substantially higher stroke death rates than the rest of the country[3].
However, the eastern part of North Carolina, South Carolina, and Georgia are part of the Buckle of the Stroke Belt. These counties in the Stroke Buckle have had the highest stroke death rates in the country for at least 30 years.[4]

[1] Snyder, W.M., deSouza Griggs, X. "Communities of Practice: A new Tool for Government Managers" (Washington, D.C.:IBM Center for te Business of Government, 2003 report).
[2] Camilo O, Goldstein LB. Statewide Assessment of Hospital-Based Stroke Prevention and Treatment Services in North Carolina: Changes over the last 5 years. *Stroke* 2003; 34(12):2945-2950.
[3] Feinleib M, Ingster L, Rosenberg H, Maurer J, Sing G, Kochanek K. Time trends, cohort effects, and geographic patterns in stroke mortality: United States. *Ann Epidemiol.* 1993;2:458-465.

B. TSSN History

On September 23 and 23, 1999, Georgia, South Carolina, and North Carolina stroke experts met for a Tri-State Stroke Summit. The Summit was a significant event. It brought representatives from three states together to share scientific findings on stroke and discuss this regional health problem. The participants proposed to "support the establishment of a Tri-State Stroke Network charged with developing and implementing a collaborative plan to address the public health challenge of the Stroke Buckle through coordinated use of federal, state and local resources" [5] In May 2000, the Summit report, *Unexplained Stroke Disparity: Report and Recommendations from Three Southeastern States* highlighted the data on the stroke burden in the three states. In October 2000, the Centers for Disease Control and Prevention (CDC) funded the proposal to establish the Tri-State Stroke Network for three years.

C. TSSN Structure

The Tri-State Stroke Network (TSSN) is comprised of 27 Active/Appointed members, approximately nine from each state and resource persons. These dedicated health professionals have expertise in stroke prevention and treatment in the region. Members represent many types of organization such as hospitals, university research centers, public health departments in the 3 states, not-for-profit organizations, and private organizations focusing on health initiatives. The CDC continues to support the Tri-State Stroke Networks activities with grant funds and technical assistance. The TSSN Executive Director coordinates the project through the NC Heart Disease and Stroke Prevention Branch.

TSSN provides a coordinated effort to assist NC, SC, and GA (all are CDC funded Basic Implementation States) with utilizing their resources for stroke prevention and treatment. Partnerships emphasize the importance of collaboration to enhance current projects and avoid duplication of efforts.

D. Public Health Framework

TSSN members follow a public health framework promoting systems-level change. This requires public health practitioners to focus on organizational, community and society- level changes[6]. In systems level work, the target client is the 'change agent not the individual person. The change agent is the person in an organization who can make decisions for the organization; those systems level decisions will ultimately effect the individual person.

Policy level initiatives, whether they are formal or informal, public or private, provide the most effective strategies to bring about changes in the social and physical environments of a community. These initiatives support individuals in making positive choices about their personal health behaviors. One example of an effective organizational-level policy that improves cardiovascular health is smoke-free buildings. Another is work-site insurance policies that encourage workers to participate in wellness programs addressing hypertension.

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[4] Howard G, Howard VJ, Katholi C, Oli M, Huston S. Decline in US stroke mortality: an analysis of temporal patterns by sex, race, and geographic region. *Stroke.* 2001; 32:2213-2220.

[5] Huston, SL, Lengerich, EJ, Pratap, A, Puckett, E. *Unexplained Stroke Disparity: Report and Recommendations from three Southeastern States.* May 2000; page 8.

[6] Schmid T, Pratt M, Hunt JR. Policy as intervention: environmental and policy approaches to the prevention of cardiovascular disease. *Am J Public Health* 1995; 85:1207-1211.

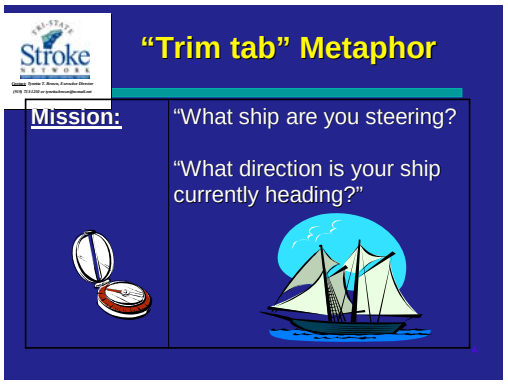
Population-based strategies focus on an identified population (e.g., individuals with hypertension) or area (e.g., residents of a region) rather than individual behavior change. One example is a media campaign to educate a target market (e.g. rural counties with high stroke morbidity rates) on the signs and symptoms of stroke. The policy level changes within organizations and the population-based strategies create social change toward healthy lifestyles.

III. Planning Process

The Tri-State Stroke Network (TSSN) convened the May 16, 2006 Summit to develop its Strategic Plan for 2006-2007.

Meeting Theme:
The meeting theme was to envision the TSSN as a "Trim Tab" using a metaphor for strategic planning derived from a statement by Buckminster Fuller:

> "Think of the Queen Mary – the whole ship goes by and then comes the rudder. And there's a tiny thing on the end of the rudder – called a trim tab…Just moving the little trim tab builds a low pressure that pulls the rudder around. Takes almost no effort at all…So, I say, call me Trim Tab."



Participants examined the direction the TSSN's ship is and was heading, then took stock of what outside currents, winds, tides and events were impacting our progress. From that point on, the group focused on where the TSSN should be going and how to navigate successfully to get there during the next few years. TSSN can be the Trim Tab that exerts pressure strategically in guiding progress in the region.

The meeting produced significant progress in each of the following areas, as reported in the sections below:

- TSSN's mission statement
- Audience
- Taking Stock: SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats), restructure committees, clarify roles and responsibilities – See Appendix
- Define and adopt goals and strategies
- Establish an Action Plan with measurable objectives for July 2006- June 2007
- Identify critical issues for TSSN's future.

IV. Strategic Plan

A. **Mission**

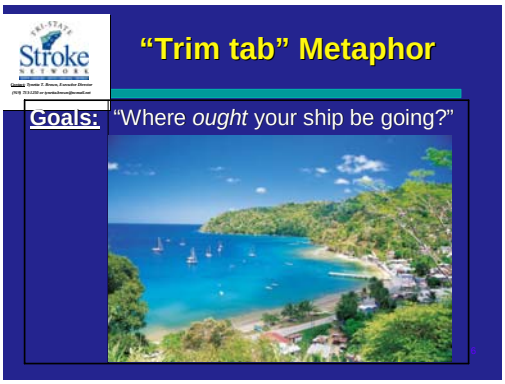
TSSN – a consortium of public health leaders and experts in stroke prevention and treatment in NC, SC, and GA – creates system and policy improvements to reduce morbidity, mortality, and reduce the impact of stroke in the "Stroke Buckle" of the 3 states.

B. **Audience**

In order to focus TSSN efforts and not duplicate other current stroke programs, the participants defined the TSSN target audience:

Key leaders in public health, health care, and health policy. The Network serves as *catalyst for change by providing information resources to these key leaders.*

C. Goals, Strategies and Objectives



Epidemiology & Data Committee:

Goal : Generate information resources based on current data that could be used to reduce the burden of stroke in the Stroke Buckle

Strategies:

- Develop GIS maps and other data resources to highlight the geographic distribution of stroke morbidity & mortality and the available resources to address the stroke burden
- Identify critical questions for population-based studies designed to explain the excess stroke death & advocate for the funding and completion of such studies.
- Develop TSSN evaluation protocols to document progress.
- Create and disseminate journal articles, white papers and presentations on the excess burden of stroke in the Tri-State area

Objective:

By December 31, 2006 – TSSN will create GIS map of NC JCAHO Certified Stroke centers and stroke mortality

Measures of Success:

- GIS maps generated and presented to policy leaders emphasizing underserved areas of greatest need for stroke-ready facilities
- SC & GA create similar GIS maps

Best Practices & Prevention Committee:

Goal: Identify and promote best practices in prevention and treatment for replication across state lines.

Strategies:

- Develop and implement initiatives to reduce hypertension in the "Stroke Buckle"
- Collaborate with state programs on systems-level projects, across multiple settings (e.g. healthcare, worksites)
- Enhance communication between states regarding stroke initiatives
- Serve as a resource to develop regional systems of care

Objective:

By June 30, 2007, TSSN will have develop a pilot project that can be replicated across the Tri-State Region to reduce hypertension in work-sites among at-risk populations

Measures of Success:

- Number of work-sites that implement project
- Number of work-sites that sustain the project by funding it completely for future year
- Project documented and presented to SC & GA

Awareness & Advocacy Committee:

Goal: Increase awareness of the burden of stroke (health, economic, social) among key decision makers to promote policy and systems change

Strategies:

- Educate policy makers using stroke-related data resources that show areas of need (e.g. GIS maps)
- Propose new and/or amended laws and regulations for prevention and control of stroke
- Collaborate with partners to strengthen and expand existing policies and recommend changes in the private sector (e.g. health insurance policies covering stroke prevention services)

Objective:

By November, 2006 the GIS maps showing NC JCAHO Certified Stroke Centers and stroke mortality will be presented to NC Justus Warren Heart Disease and Stroke Prevention Task Force (legislators)

Measure of Success:

- GIS maps presented to NC legislators and information incorporated in recommendations
- Share information with SC & GA leaders in health policy

Health Disparities Committee:

Goal: Reduce stroke-related health disparities in the Tri-State Region

Strategies:

- Gather and disseminate information on stroke-related health disparities
- Work with other TSSN committees to integrate health disparities in data, programs, and policies:
  - Epidemiology and Data - Share data information sources that highlight differences in disability, hospitalizations, care, receipt of tPA or other therapies, and the limited availability of stroke-related data in disparate populations.
  - Awareness and Advocacy – Increase awareness among policy-makers on the burden of stroke in at-risk populations
  - Best Practices & Prevention - Highlight interventions designed to reduce disparities in stroke care

Objective:
By June 30, 2007 – Health Disparities Survey Data will be completed, analyzed and disseminated to educate legislators and other key decision makers

Measures of Success:

- Survey information compiled and report generated
- Information presented to policy makers

D. Evaluation Plan

The TSSN Evaluation Plan is based on the Logic Model and Committee Annual Action Plans. The Logic Model provides a visual map of the link between activities and intended outcomes. It will help identify evaluation questions and prioritize data needs which can be used for continuous quality improvement. The Annual Action Plans describe committee objectives, activities, and measures of success and are updated annually.

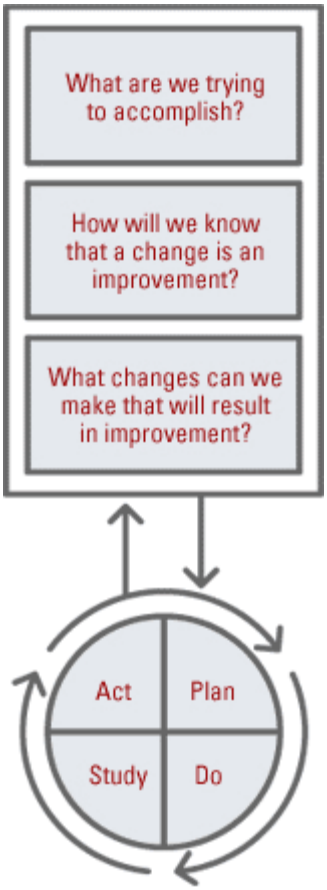
The development and implementation of the TSSN Evaluation Plan will be guided by the Epi & Data Subcommittee and the Executive Director. Evaluation Plan development will be done collaboratively with the NC, SC, and GA Heart Disease & Stroke Prevention Program Managers to better integrate Network evaluation activities and findings with state initiatives. Evaluation activities will be guided by the needs of the network to document accomplishment of activities, leveraged resources, and the spread of best practices across the network; to improve the effectiveness of network projects; and to identify program outcomes.

Reports on evaluation activities will be shared annually with the Executive Committee to determine progress toward achieving annual objectives. Evaluation Reports to date include a compilation of participant surveys of conference calls, meetings, and summits. Projects implemented by TSSN will also be evaluated.

The TSSN Strategic Plan asks the question:

The TSSN Evaluation Plan asks the question:

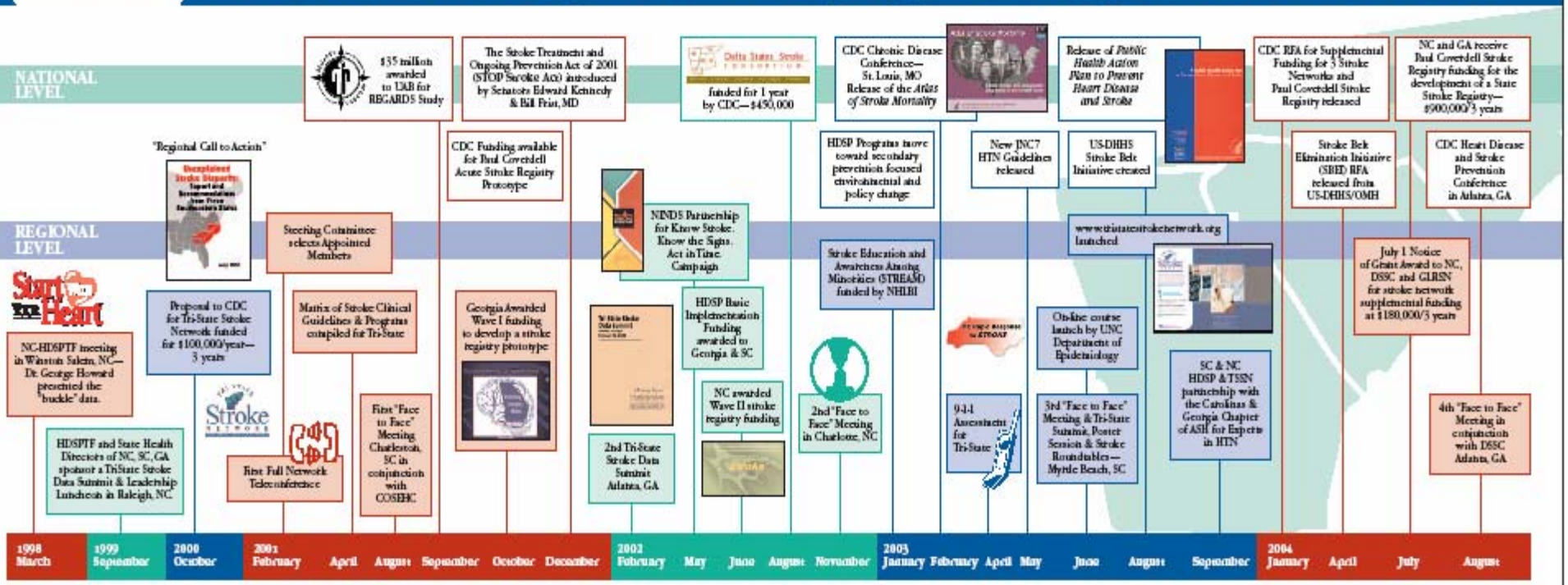
Information from the Evaluation Report based on Outcomes and Action Plans guides future efforts by asking:



Plan-Do-Study-Act (PDSA) was developed by W. Edwards Deming (Deming WE. The New Economics for Industry, Government Education)

Langley GL, Nolan TW, Norman CL, Provost LP. Improvement Guide: APractical Approach to Enhancing Organizational Performance.

Building a Network Infrastructure to Address Regional Geographic Disparities in Stroke



Methods Used:

A variety of process objectives were utilized from the formation of a Tri-State Stroke Summit Steering Committee and subsequent Work Group for establishing goals and objectives to infrastructure building for the administration of the Network.

Results:

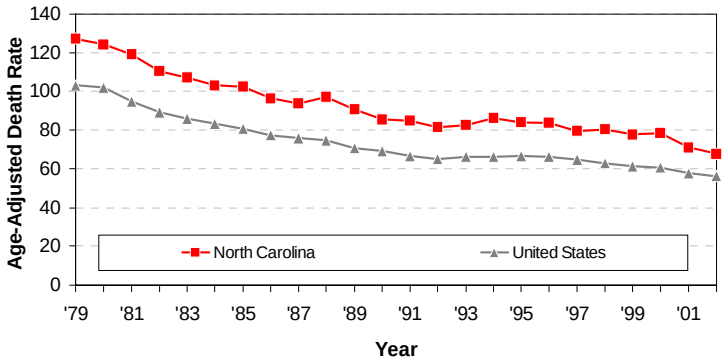
Through the Tri-State Stroke Network (TSSN), there is now a coordinating body to assist CDC-funded Basic Implementation States with utilizing their resources to address stroke and secondary prevention for improved prevention and control, and acute stroke care. Partnerships emphasize the importance of collaboration to enhance and support work in stroke and help to avoid duplication of effort. Additional networks/consortiums have been funded-Delta States Stroke Consortium and the Great Lakes Regional Stroke Network.

Conclusions:

A stronger infrastructure has been created within the "buckle" of the Stroke Belt to address the geographic disparity in stroke. No one source can provide what is needed to adequately address the third leading cause of death. A shared problem, limited resources and an agreement to collaborate, provide stronger opportunities to address a critical health problem on a larger scale. Continuing to add partners to assist in achieving shared goals helps contend with sustainability issues. Communication and the shared commitment from all partners is key to success and has laid a foundation of trust and experience within the TSSN to continue to bring attention to the extreme burden of stroke.

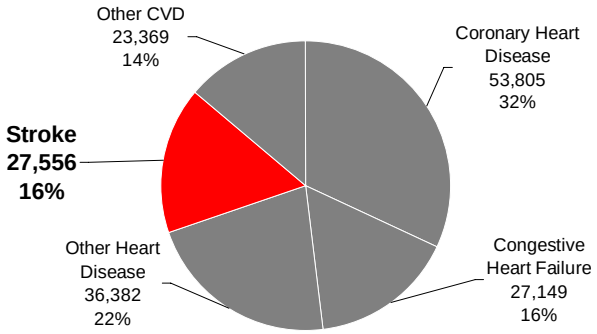
Appendix B: Stroke Data
North Carolina

Figure 2.3. Stroke Death Rates, 1979-2002



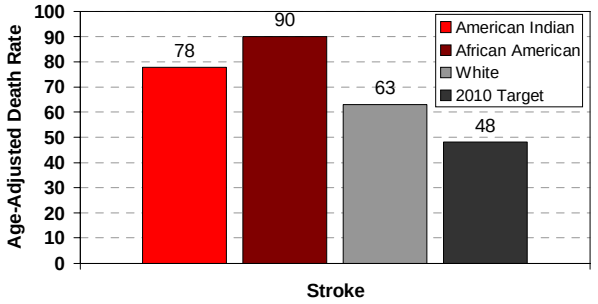
1999-2002: ICD-10 codes I60-I69; 1979-1998: ICD-9 codes 430-434,436-438 multiplied by comparability ratio of 1.0588.
Rates per 100,000 population, age-adjusted to the 2000 U.S. standard population.
Data Source: Compressed Mortality File, CDC Wonder.

Figure 2.11. Number and Percentage of Total CVD Hospital Discharges that were Due to Stroke, North Carolina, 2003



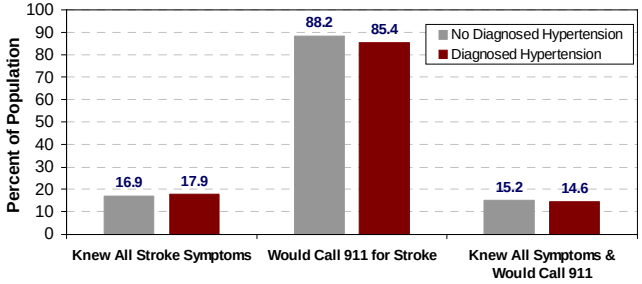
ICD-9-CM codes: Cardiovascular Disease 390-459; Heart Disease 391-392.0, 393-398, 402, 404, 410-416, 420-429; Coronary Heart Disease 410-414 ; Congestive Heart Failure 428.0; Stroke 430-438.
Principal diagnosis only; N.C. residents only.
Data Source: N.C. Hospital Discharge Database, State Center for Health Statistics.

Figure 2.6. Death Rates by Race Groups & Healthy People 2010 Target, N.C., 2002



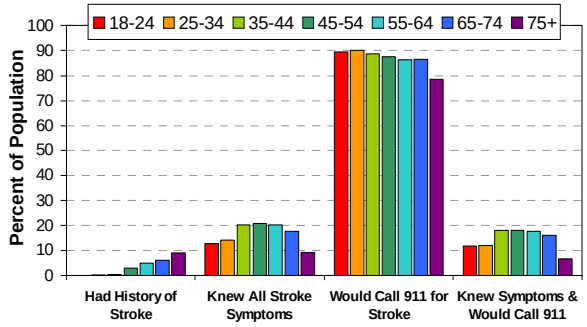
Stroke: ICD-10 codes I60-I69.
Rates per 100,000 population, age-adjusted to the 2000 U.S. standard population.
Data Source: DATA2010, CDC, NCHS.

Figure 2.25. Stroke Awareness by Hypertension Status, N.C. Adults, 2003



Data Source: N.C. Behavioral Risk Factor Surveillance System
Adults = ages 18+ years

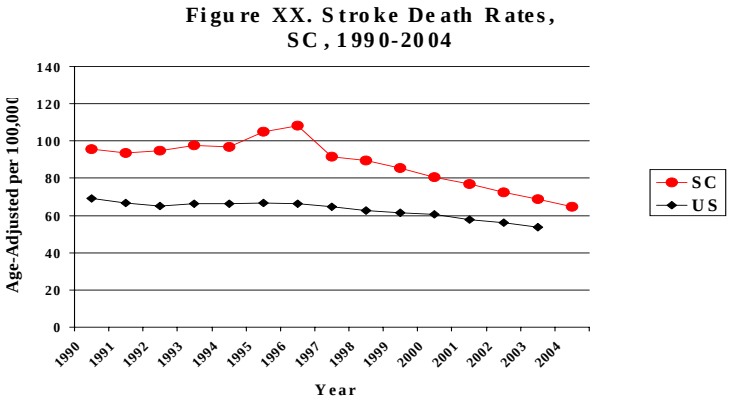
Figure 2.15. Stroke History and Knowledge among N.C. Adults by Age Group, 2003



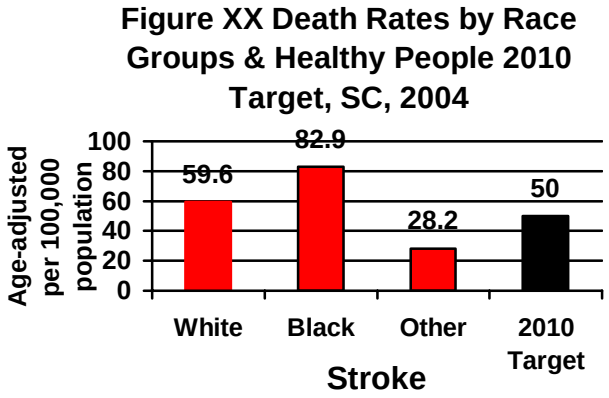
Data Source: N.C. Behavioral Risk Factor Surveillance System
Adults = ages 18+ years

Appendix B: Stroke Data

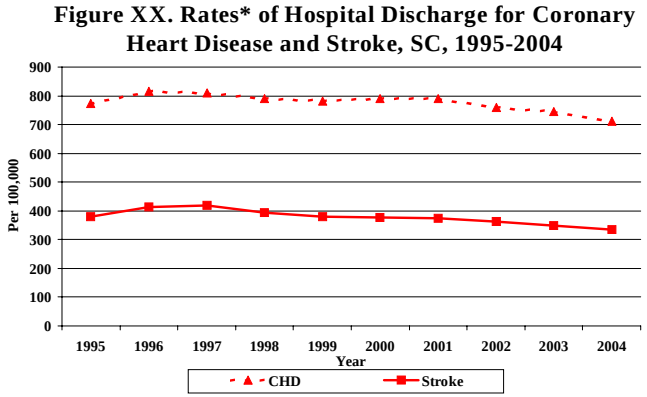
South Carolina



1990-1998 rates multiplied by comparitablity ratio of 1.0588.
Age-adjusted to the 2000 U.S. standard population.
Data Source: Vital Statistics, SCDHEC

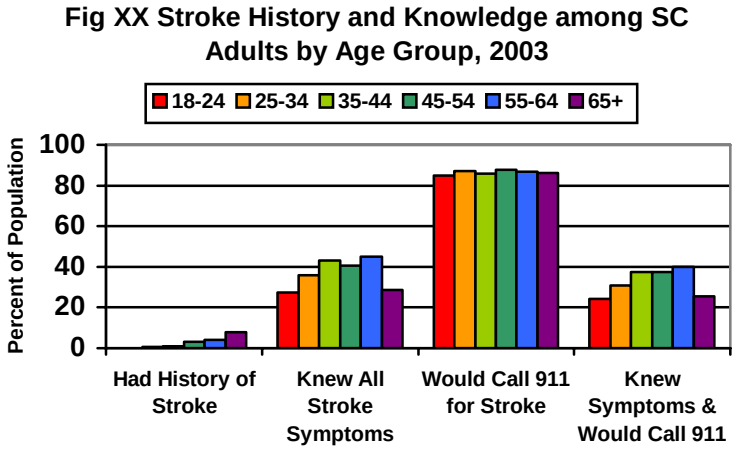


Age-adjusted to the 2000 U.S. standard population.
Data Source: Vital Statistics, SCDHEC



•Age-adjusted to year 2000 population

Data source: Hospital Discharge Survey, SC Budget and Control Board, Office of Research and Statistics

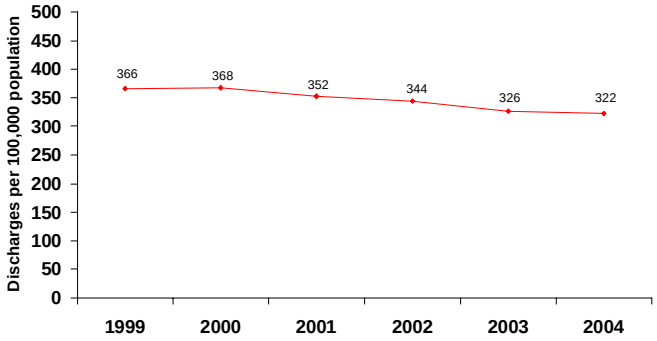


Data Source: SC BRFSS

Appendix B: Stroke Data

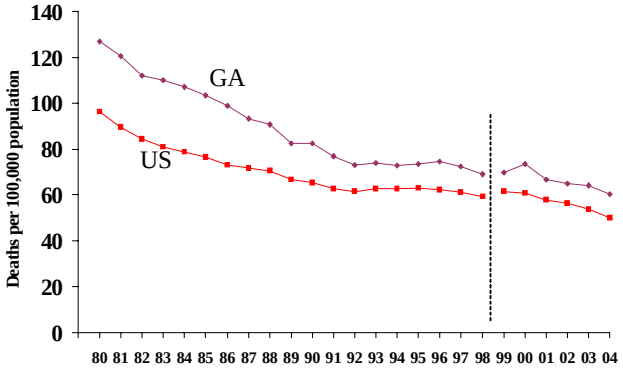
Georgia

Figure 8. Age-adjusted stroke hospitalization rates, Georgia, 1999-2004



The number of persons discharged from non-Federal, acute-care facilities for stroke.

Figure 3. Age-adjusted stroke death rates, Georgia and the United States, 1980-2004



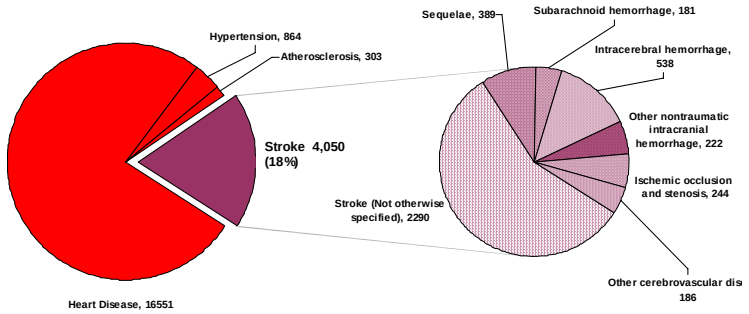
NOTE. The dotted line indicates a change in coding systems used for cause of death. ICD-9 codes were used for 1980-1998 deaths; ICD-10 codes were used for 1999-2004 deaths.

Table 5. Individual stroke sign/symptom awareness among adults, Georgia, 2005

Stroke signs/symptoms	Percentage of adults who correctly identified it
Body numbness or weakness, especially on one side	97%
Sudden confusion or trouble speaking	95%
Sudden dizziness, trouble walking, or loss of balance	94%
Sudden vision trouble	86%
Severe unexplained headache	79%

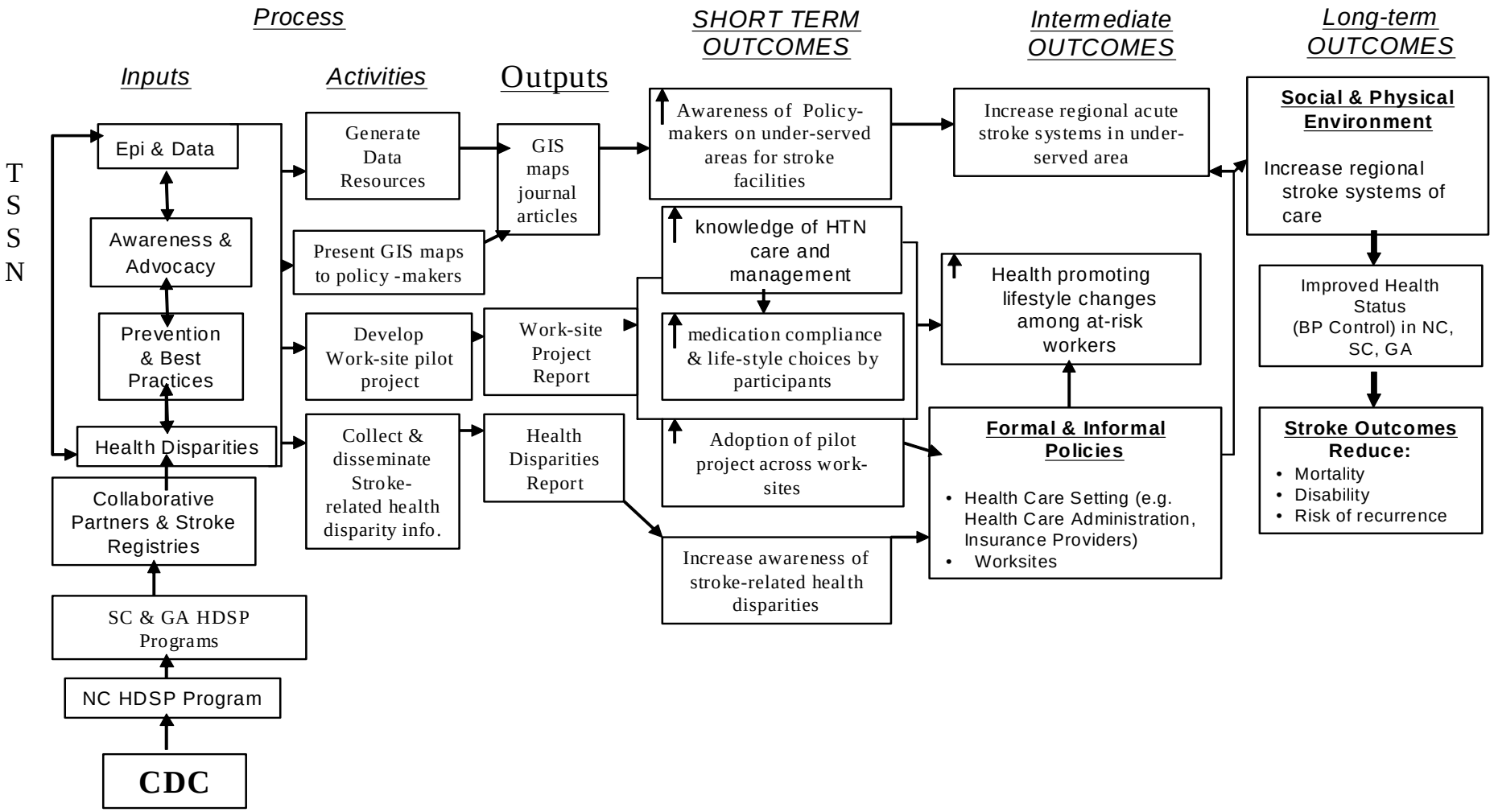
NOTE: The BRFSS questions pertaining to awareness were asked in a prompted format. For example, "Do you think X is a symptom of stroke."

Figure 2. Cardiovascular disease deaths and stroke sub-classification, Georgia, 2004



Appendix C: Logic Model

Tri-State Stroke Network - Logic Model



APPENDIX – D: SWOT ANALYSIS

Taking Stock

1. SWOT Analysis: Strengths, Weaknesses, Opportunities and Threats. Strengths & Weaknesses focus on the organization's internal factors. Opportunities and Threats focus on factors external to the organization. All of these factors represent critical elements for the organization's leaders to examine during strategic planning.

The facilitator for the Strategic Planning process gathered qualitative data from the TSSN via key informant interviews. The purpose was to gather information from the members on the strengths of the Network, the areas that needed to be improved and future directions. Each individual was asked the same set of questions. The SWOT Analysis results are listed in the Appendix.

2. Restructure Committees and more clearly define Committee's purpose: TSSN currently has 5 Committees: The Executive Committee to guide the Network toward its goals, and the 4 Subcommittees that work synergistically to identify and implement strategies to reach those goals. The Goals and Strategies relate to each of the Subcommittees listed below.

- Best Practices/Prevention
- Epidemiology & Data Collection
- Awareness & Advocacy
- Health Disparities

3. Roles & Responsibilities: In order for TSSN to effectively achieve the mission, the participants agreed that the roles and responsibilities of the members needed to be more clearly defined. Furthermore, the manner in which individuals were appointed and the length of service required clarification. In that way, those people who were interested in becoming active could obtain a better understanding of the potential commitment.

Results

Strengths, **W**eaknesses, **O**pportunities and **T**hreats (From SWOT Analysis examining TSSN)

1. Strengths

- Location, Location, Location: "Buckle" of the Stroke Belt
- Collaboration
- GIS mapping- SC, NC, & GA
- Diversity of membership
- Access to data in 3 states

- Experts in field
- Ability to influence policy

2. Weakness

- Lack of focus. What are our expectations, roles and responsibilities?
- Distraction of individual state projects
- Lack of funding for network projects and personal. No dedicated % effort for individual investigators

3. Threats

- Funding sustainability
- Individual state initiatives/distractions
- Government complexity- "layers"
- Ownership
- Lack of definition- 3 states together vs. 1 state

4. Opportunities

- "Network" – membership
- Incubators
- Demographics – "Stroke Buckle"
- Equal Players
- Regional stroke systems beginning to develop with Acute Care (i.e. Dispatch, EMS, Hospitals)
- Developing a strategic plan and evaluation

Appendix E- Roles & Responsibilities

(Revised July 2006)

TSSN Staff:

- **Executive Director** (full-time position) Leads the Tri-State Stroke Network *Strategic Planner, Manager, Evaluator, Marketing Director*:
- **Administrative Assistant** (half-time position) supports TSSN with travel, meetings, correspondence

TSSN Members:

- Staff, Chair & Vice-Chair, Executive Committee, Active Committee members, Ex Officio

Chair & Vice-Chair:

- The positions rotate among the 3 states
- Length of service: 2 year terms for Chairs and Vice-Chairs of Subcommittees and 2 year terms for Chair, Vice-Chair and Chairman-Elect and Past-Chair of the Network. This means the Chair serves 1 year as Vice-Chair and 1 year as Chair for the Network.
- Terms of office: The Chair and Vice Chair begin their terms at the start of each calendar year beginning in 2007

Chairperson

- Presides over quarterly meetings of the Executive Committee, the Full Network and the yearly Stroke Summit, Face-to-Face meeting and the Executive Committee Leadership meeting. Determines the agenda of the Executive Committee meeting with the Executive Director.
- Guides the direction of the Network. Assists Executive Director and Executive Committee with Strategic Planning for the Network (3 year plan) and Action Planning for the Committees.
- Serves as Mentor/Sounding Board to Executive Director. These 2 people function as a team to create the vision and guide the Network in achieving goals.
- Consults with Executive Director on TSSN budget for upcoming grant cycle. Provides feedback on alignment of budget with TSSN Action plan.

Vice-Chair, Chairman-Elect

- Presides over meetings in the absence of the Chair
- May succeed to Chair at the end of Chair's 1st year
- 1 year of service in this role

Past-Chair

- Chairs the Nominating Committee
- Works with the Executive Director and Executive Committee to appoint (suggest) replacements for any vacant positions in the Executive Committee as they arise.

- Gets input from the 3 state Heart Disease & Stroke Prevention Directors on potential candidates

Executive Committee

- Consists of Chair, Vice-Chair, Past Chair, Executive Director and 4 Committee Chairs
- Meets quarterly to assist with determining agendas for the Full Network meetings, annual Face to Face meeting of the entire Network and Executive Committee Action Planning Meeting
- As grant funds allow, the Executive Committee will be reimbursed for travel to Leadership Meeting for annual Action Planning and nominating new chairs, etc.
- Works with Executive Director to consider possible outside funding sources or partners for specific projects

Committee Chairs

- Preside over quarterly meetings
- Determine agendas with assistance from the Executive Director
- Suggests possible speakers/presenters for quarterly meetings that will further the knowledge of members as it relates to stroke and the Committee's goals
- Assists Executive Director in creating a draft work-plan for the Committee
- Works with Executive Director to track progress in accomplishing goals and objectives in the current work- plan. Reviews Evaluation Report developed and maintained by Executive Director

Committee Vice-Chairs

- Preside over quarterly meetings in the absence of Subcommittee Chair
- Serves as Chair-Elect to eventually serve as Chair of Subcommittee
- Works with Chair and Executive Director to develop Committee Work-plan

Nominating Committee

- Chaired by Past TSSN Chairperson
- Strives to maintain equal representation of members across 3 states and rotation of Chair persons across states and representation from all phases of stroke prevention and treatment
- Nominates Vice-Chair, Chairman-Elect of the Network
- Nominates new Active /Appointed members of the Network based on person's stroke expertise and interest in active involvement in TSSN.
- Maintains a current member directory (updates sent to Chair by TSSN staff)

27- 30 Active / Appointed Members

- Have leadership roles and expertise in stroke in their respective State
- Represent all 3 states
- Can represent TSSN as appropriate at meetings and conferences

- As grant funds allow, the Active Members (including Exec. Committee) will be reimbursed for travel to annual Stroke Summit and Face-to-Face meeting
- Actively involved in TSSN activities:
  - Participate in conference calls
  - Work with committee members to develop and deliver TSSN current projects (i.e. GIS maps, journal articles, Stroke-related Health Disparities Survey, policy issues such as Stroke bill, stroke systems of care)

Ex-Officio members:

- State Health Directors from NC, SC, and GA.
- Receive minutes from Full Network meetings only and published documents (e.g. Stroke Summit Report, Strategic Plan, journal articles).

National Liaisons:

- Provides literature and data on stroke prevention and treatment. From related multi-disciplinary entities (i.e. NINDS, CDC, NHLBI, etc.

TSSN List Serve:

- Included in email correspondence for updates on TSSN activities (meeting minutes), events (e.g. stroke conferences), and stroke-related news (e.g. data, latest journal articles on stroke, etc.)
- Receive TSSN yearly calendar for conference calls. May participate (as guest) in conference calls.
- Will be invited to TSSN Stroke Summits and Face-to-Face Meetings. Will not be reimbursed for travel expenses to TSSN Stroke Summit or other TSSN meetings.
- May represent other national partners (AHA/ASA, NSA, other stroke networks, etc.)

Appendix F: Critical Issues for TSSN's Future

1. **Who is our audience?**
   Key leaders in public health, health care, policy makers. The Network serves as catalyst for change by providing information resources to these key leaders.

2. **What makes TSSN unique?** Don't have to be unique as long as relevant (working on same goals)
   a) Departments of Health
   b) Epidemiologists
   c) Regional approach that promote advocacy and collaborated across borders with regard to:
      - Providers for best clinical practices
      - Data collection and sharing: public health & epidemiology
      - Advocacy affecting public policy

3. **Can we maintain or increase TSSN's funding?**

4. **Can we restructure for better decision-making?**
   Clearly define Committees & roles/responsibilities
      - Best Practices/Prevention
      - Data Collection and Epidemiology
      - Policy
      - Health Disparities

5. **Can we fully engage our members?**
   d) If members are part time volunteers, difficult to ask for more time
   e) Engage Department of Health
   f) Key on members expertise
   g) Use TSSN staff as leaders
   h) Engage more state level staff

6. **How can we improve implementation?**
   i) Data (generation & tools) focus # all groups
   j) Collect data to present to key decision makers
   k) Focus on goals to provide direction to group
   l) Communicate more frequently
   m) Short term strategy – smaller groups/ limit groups
   n) Each state staff the leadership of each group
   o) Overarching goals, address Health Disparities, enhance state HDSP efforts
   p) Epidemiology and Data