



**SOUTH DAKOTA
CARDIOVASCULAR
COLLABORATIVE**

The South Dakota Cardiovascular Collaborative and the Statewide Cardiovascular Strategic Plan

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South Dakota Department of Health

The Cardiovascular Collaborative

The South Dakota Cardiovascular Collaborative is a group of medical and public health representatives who want to improve the quality of life for all South Dakotans through prevention and control of heart disease and stroke.

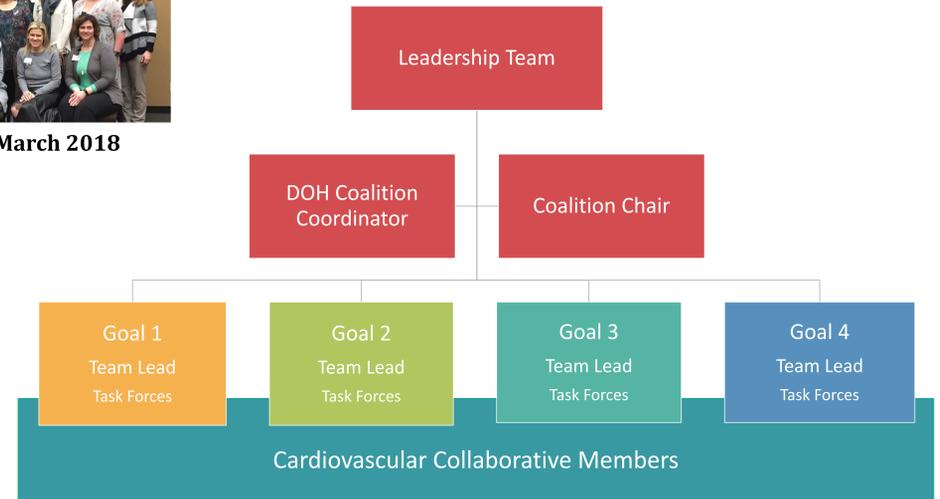
The Collaborative includes diverse representatives from across South Dakota, including:

- American Heart Association
- Avera Health System
- Community Healthcare Association of the Dakotas
- Community Health Center of the Black Hills
- Dakota State University
- Dept. of Social Services
- Fall River Health
- Great Plains Tribal Chairman's Health Board
- Great Plains Quality Innovation Network
- Health Management Partners
- HealthPOINT
- Horizon Healthcare
- Huron Clinic Foundation
- Indian Health Services
- Lewis Family Drug
- Paramedics Plus
- Prairie Lakes Healthcare
- Regional Health System
- Rural Health
- Sanford Health System
- Sioux Falls Dept. of Health
- SD State Medical Association
- SD Association of Healthcare Organizations
- SD Department of Health
- SD EMS Association
- South Dakota State University
- Sioux Falls VA
- Sisseton-Wahpeton
- SD Health Link
- Spearfish Ambulance
- University of Sioux Falls
- Urban Indian Health



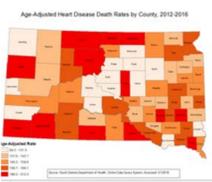
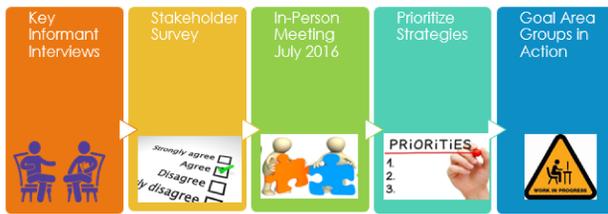
Annual Meeting March 2018

Organizational Structure



The Strategic Plan

Planning Process



State Data

2017-2021 Strategic Plan

South Dakota Cardiovascular Collaborative

Vision: Healthy people, healthy communities, healthy South Dakota
Mission: Improve quality of life of all South Dakotans through prevention and control of heart disease and stroke

Strategic Plan 2017-2021

Goals			
I. IMPROVE DATA COLLECTION Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke.	II. PRIORITY POPULATIONS Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke.	III. CONTINUUM OF CARE Coordinate and improve continuum of care for heart disease and stroke.	IV. PREVENTION & MANAGEMENT Enhance prevention and management of heart disease and stroke.
Objectives			
1. Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021. 2. Increase input into at least 4 state collection tools by organizations and individuals by 2021.*	1. Increase the number of EMS in South Dakota from 3,281 EMS in 2016 to 3,850 EMS by 2021.* 2. Decrease the age-adjusted death rate due to heart disease in the American Indian population from 212.5 per 100,000 to 202.5 per 100,000 by 2021.* 3. Decrease the age-adjusted death rate due to stroke in the American Indian population from 48.5 per 100,000 to 45 per 100,000 by 2021.*	1. Decrease emergency response times by decreasing average ambulance chute times from 4.3 minutes to 3.8 minutes by 2021.* 2. Reduce 30-day readmission rate for heart disease and stroke from 6.09% to 5.9% by 2021.*	1. Decrease prevalence of heart attack from 4.7% (2015) to 4.4% (5% decrease) by 2021.* 2. Decrease prevalence of stroke from 2.6% (2015) to 2.47% (5% decrease) by 2021.*
Strategies			
A. Identify and promote tracking of a common set of minimum cardiovascular health data for use for both prevention and improvement of post-cardiac event outcomes.	A. Promote the different models of team-based, patient-centered care (health cooperative clinic, health homes, PCMH). B. Maximize community-clinical linkages (e.g. CHW, different sectors). C. Support policies that increase access to heart disease and stroke care for priority populations. D. Improve collaboration with tribal communities. E. Explore innovative strategies to sustain EMS services (e.g. funding, training).	A. Develop pilot program for cardiac ready communities. B. Ensure utilization of community-based resources and programs such as Mission, Lifeline and LUCAS for EMS services. C. Engage non-physician providers in team-based approach to care via implementation of mobile integrated health model. D. Utilize results of needs assessment to address infrastructure and sustainability of EMS.	A. Encourage the implementation of quality improvement processes in health systems. B. Promote awareness, detection and management of high blood pressure (clinical innovations, team-based care, and self-monitoring of blood pressure). C. Expand prevention and lifestyle interventions in communities and for all ages across the lifespan.

Source: 1. CDC, 2. Data from Healthcare Workforce, 3. SDHHS, 4. SDHHS, 5. SDHHS, 6. SDHHS, 7. SDHHS, 8. SDHHS, 9. SDHHS, 10. SDHHS, 11. SDHHS, 12. SDHHS, 13. SDHHS, 14. SDHHS, 15. SDHHS, 16. SDHHS, 17. SDHHS, 18. SDHHS, 19. SDHHS, 20. SDHHS, 21. SDHHS, 22. SDHHS, 23. SDHHS, 24. SDHHS, 25. SDHHS, 26. SDHHS, 27. SDHHS, 28. SDHHS, 29. SDHHS, 30. SDHHS, 31. SDHHS, 32. SDHHS, 33. SDHHS, 34. SDHHS, 35. SDHHS, 36. SDHHS, 37. SDHHS, 38. SDHHS, 39. SDHHS, 40. SDHHS, 41. SDHHS, 42. SDHHS, 43. SDHHS, 44. SDHHS, 45. SDHHS, 46. SDHHS, 47. SDHHS, 48. SDHHS, 49. SDHHS, 50. SDHHS, 51. SDHHS, 52. SDHHS, 53. SDHHS, 54. SDHHS, 55. SDHHS, 56. SDHHS, 57. SDHHS, 58. SDHHS, 59. SDHHS, 60. SDHHS, 61. SDHHS, 62. SDHHS, 63. SDHHS, 64. SDHHS, 65. SDHHS, 66. SDHHS, 67. SDHHS, 68. SDHHS, 69. SDHHS, 70. SDHHS, 71. SDHHS, 72. SDHHS, 73. SDHHS, 74. SDHHS, 75. SDHHS, 76. SDHHS, 77. SDHHS, 78. SDHHS, 79. SDHHS, 80. SDHHS, 81. SDHHS, 82. SDHHS, 83. SDHHS, 84. SDHHS, 85. SDHHS, 86. SDHHS, 87. SDHHS, 88. SDHHS, 89. 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