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SOUTH DAKOTA  
CARDIOVASCULAR  
COLLABORATIVE

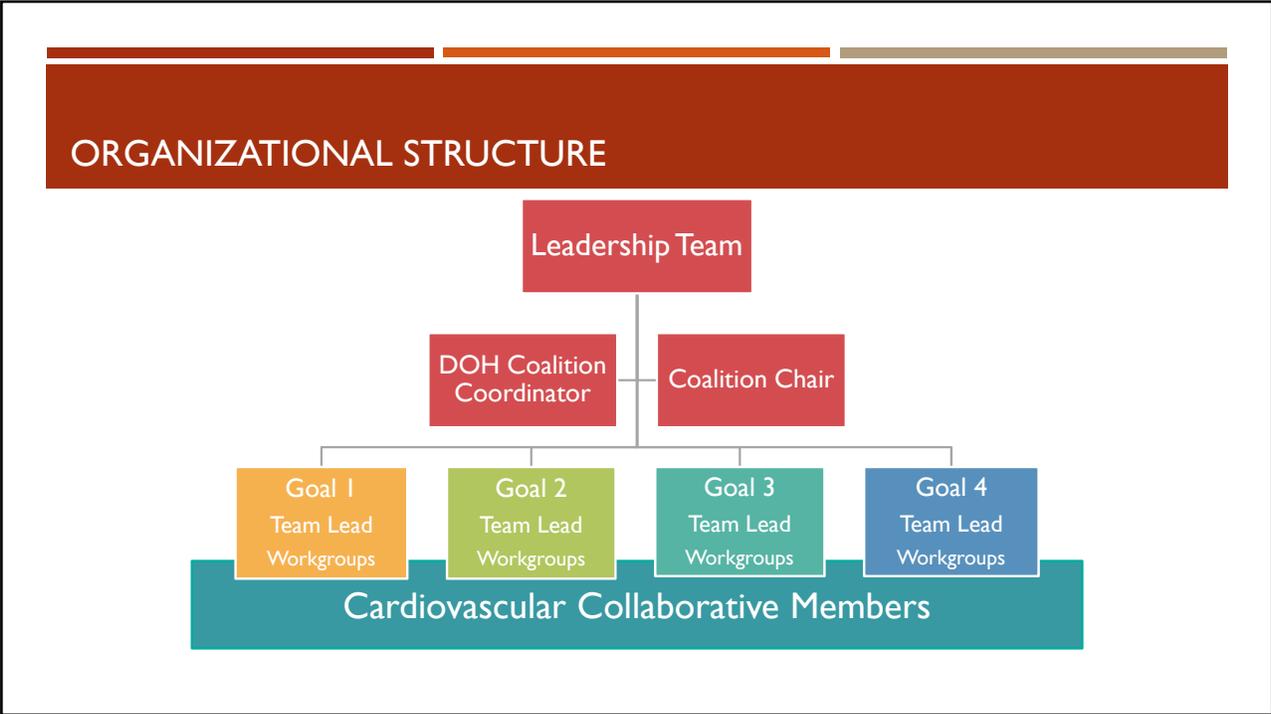
**MID-YEAR VIRTUAL MEETING**

October 30, 2017  
1:00-2:30pm CT

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**MARY MICHAELS**  
CHAIR, CARDIOVASCULAR COLLABORATIVE





**TODAY'S AGENDA**

The Strategic Plan & Priority Strategies	Rachel
Quality Improvement Presentation (ECQIP)	Lori Thomas
Cardiovascular Collaborative Accomplishments	Rachel, Mary
Open Mic	Everyone
Wrap Up and Reminders	Rachel

South Dakota Cardiovascular Collaborative				Strategic Plan 2017-2021
<p><b>Vision:</b> Healthy people, Healthy communities, Healthy South Dakota  <b>Mission:</b> Improve quality of life of all South Dakotans through prevention and control of heart disease and stroke</p>				<p>Download the entire South Dakota Cardiovascular Collaborative Strategic Plan at <a href="http://doh.sd.gov/diseases/chronic/heartdisease">doh.sd.gov/diseases/chronic/heartdisease</a></p>
Goals				
<p><b>I. IMPROVE DATA COLLECTION</b> Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke.</p>	<p><b>II. PRIORITY POPULATIONS</b> Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke.</p>	<p><b>III. CONTINUUM OF CARE</b> Coordinate and improve continuum of care for heart disease and stroke.</p>	<p><b>IV. PREVENTION &amp; MANAGEMENT</b> Enhance prevention and management of heart disease and stroke.</p>	
Objectives				
<ol style="list-style-type: none"> <li>Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021<sup>1</sup>.</li> <li>Increase input into at least 4 data collection tools by organizations and/or individuals by 10% by 2021.<sup>2</sup></li> </ol>	<ol style="list-style-type: none"> <li>Increase the number of EMTs in South Dakota from 3,281 EMTs in 2016 to 3,850 EMTs by 2021.<sup>3</sup></li> <li>Decrease the age-adjusted death rate due to heart disease in the American Indian population from 212.5 per 100,000 to 202.0 per 100,000 by 2021.<sup>4</sup></li> <li>Decrease the age-adjusted death rate due to stroke in the American Indian population from 48.5 per 100,000 to 46 per 100,000 by 2021.<sup>4</sup></li> </ol>	<ol style="list-style-type: none"> <li>Decrease emergency response times by decreasing average ambulance chute times from 4.3 minutes to 3.8 minutes by 2021.<sup>5</sup></li> <li>Reduce 30-day readmission rate for heart disease and stroke from 6.09% to 5.9% by 2021.<sup>5</sup></li> </ol>	<ol style="list-style-type: none"> <li>Decrease prevalence of heart attack from 4.7% (2015) to 4.45% (5% decrease) by 2021.<sup>6</sup></li> <li>Decrease prevalence of stroke from 2.6% (2015) to 2.47% (5% decrease) by 2021.<sup>6</sup></li> </ol>	
Strategies				
<p>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.</p>	<p>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 (ex: funding, training).</p>	<p>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.</p>	<p>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.</p>	

PRIORITY STRATEGIES			
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# ECQIP

LORI THOMAS MSN RN  
CLINICAL QUALITY MANAGER  
COMMUNITY HEALTHCARE ASSOCIATION OF THE DAKOTAS



## CARDIOVASCULAR COLLABORATIVE ACCOMPLISHMENTS



CARDIOVASCULAR COLLABORATIVE LOGO



QUARTERLY NEWSLETTERS

Purpose: Highlight progress updates from goal area workgroups, upcoming events, community spotlight stories, and other Cardiovascular Collaborative news

- [Fall 2018](#) – sent Oct 27, 2018
- [Summer 2018](#)
- [Spring 2018](#)
- [Winter 2017/2018](#)
- [Fall 2017](#) – first newsletter Oct. 2017

Newsletter not in your inbox? Check your junk mail folder and add [Rachel.Sehr@state.sd.us](mailto:Rachel.Sehr@state.sd.us) to your list of safe senders.

**South Dakota Cardiovascular Collaborative**

**The Heart of the Matter**  
The South Dakota Cardiovascular Collaborative  
Quarterly Update, Summer 2018

**Upcoming Events**

**Move Well Sioux Falls Fitness Festival**  
This 4-cycle festival features opportunities for community members to try a variety of physical activities in one place!

**SATURDAY, AUGUST 11**  
Horseshoe Park (5550 E. 24th St., Sioux Falls, SD 57105)  
9:00AM-12:00 NOON

**Community Spotlight**

**Heart Screenings Protect Against Disease, Save Lives**  
Eric van Duinen always felt that a healthy life for every individual brought forth at such a high cost for having a heart attack, especially at age 51.

**South Dakota Chronic Disease Prevention & Health Promotion Annual Partners Meeting**  
Save the Date for the annual South Dakota Chronic Disease Prevention & Health Promotion Annual Partners Meeting **October 8-9, 2018** at the Highland Conference Center in Mitchell!

## POSTER PRESENTATION AT CHRONIC DISEASE PARTNERS MEETING

The poster, titled "The South Dakota Cardiovascular Collaborative and the Statewide Cardiovascular Strategic Plan," is presented by Rachel Sehr, Kiley Hump, Ashley Miller, and Marty Link from the South Dakota Department of Health. The poster is divided into several sections: "The Cardiovascular Collaborative" (listing members and goals), "Organizational Structure" (a flowchart), "The Strategic Plan" (a grid of strategic goals), "Priority Strategies for Goal Area Task Forces (2018-2021)", and "Key Accomplishments" (listing various initiatives like the Cardiovascular Risk Survey, Team-Based Care Guide, and Quality Improvement Toolkit).

## TEAM-BASED CARE TOOLKIT

- **The Priority Populations Workgroup (Goal 2)** has been working to promote team-based patient-centered care in South Dakota.
- This free tool helps create conversations and raise awareness in order to strengthen team-based care in South Dakota.
- This toolkit is perfect for hospital administrators, quality improvement professionals, public health professionals, and anyone with a vested interest in team-based care.
- Available at: <https://doh.sd.gov/diseases/chronic/heartdisease/teambasedcareguide/>

The screenshot shows the South Dakota Department of Health website. The main navigation bar includes "HOME", "DISEASES & CONDITIONS", "CHRONIC DISEASE", and "HEART DISEASE AND STROKE PREVENTION". The "DISEASES & CONDITIONS" menu is expanded, showing categories like "Healthcare-Associated Infections", "Chronic Disease", "Diabetes Prevention and Control Program", "Heart Disease and Stroke Prevention", "Heart Attack", "Stroke", "Blood Pressure", "Cholesterol", "Heart Disease and Stroke State Plan", "Cardiac Ready Communities", "Team-Based Care Guide", "Quality Improvement Resource Guide", "Breast and Cervical Cancer Control (All Women Count)", "Colorectal Cancer Screening", and "Comprehensive Cancer Control Program". The "Team-Based Care Guide" is highlighted. The main content area features the "TEAM-BASED CARE TOOLKIT OUTLINE" with sections for "INTRODUCTION" (including "What is Team-Based Care?" and "Why is Team-Based Care an Effective Way to Provide Care?"), "MODELS OF TEAM-BASED CARE" (including "Patient-Centered Medical Homes", "P4C? Learn more + case study + resources", "Medicaid Health Homes in Action in SD Resources", and "Other Forms of Team-Based Care Learn + case study + resources"), and "TOOLS & RESOURCES".

## CARDIAC READY COMMUNITIES

- **The Continuum of Care Workgroup (Goal 3)** has been working to develop a pilot program for cardiac ready communities.
- Created the South Dakota Cardiac Ready Communities (CRC) Program Guide.
- The focus of the CRC Program is to educate, equip, and empower local community members to be better prepared and more confident in helping a patient experiencing a cardiac event prior to the ambulance arriving.
- Available at: <https://doh.sd.gov/diseases/chronic/heartdisease/cardiacreadycommunities.aspx>



## QUALITY IMPROVEMENT RESOURCE GUIDE

- **The Prevention and Management Workgroup (Goal 4)** has been working to encourage the implementation for quality improvement processes in health systems.
- The purpose of this guide is to familiarize you with quality improvement processes as a way of improving clinical quality.
- Many examples in the guide are related to cardiovascular disease, the quality improvement process can be applied to any process or condition where improvements are needed.
- Available at: <https://doh.sd.gov/diseases/chronic/heartdisease/qitoolkit.aspx>



We're looking to include case studies that highlight QI practices in South Dakota Facilities. Contact [Rachel.Sehr@state.sd.us](mailto:Rachel.Sehr@state.sd.us) and let us know what you're doing related to QI.

# ANNUAL IN-PERSON MEETING – MAY 10, 2019

- May 10, 2019 in Sioux Falls
- What do you want or need for this meeting?



Group photo Annual Meeting 2018



OPEN MIC



IN SUMMARY.....

- Look for opportunities to get involved
- Look for learning opportunities through upcoming webinars
- Save the date for May 10<sup>th</sup> In-Person meeting
- Recording of this meeting will be available on DOH website



Thank you!