2020 Annual Meeting

Session 1: Moving Forward Stronger & Together: Lessons Learned from the Impacts of COVID-19

September 2, 2020
9:00 - 10:30 am CT
Welcome!

Welcome to Session 1:
Moving Forward Stronger &
Together: Lessons Learned from the
Impacts of COVID -19
of the 2020 Cardiovascular
Collaborative Annual Meeting!

Rachel Sehr, BSN, RN
Heart Disease & Stoke
Prevention Coordinator
Today's Agenda

• Looking Back: Key Accomplishments of the Cardiovascular Collaborative
• Short Break
• Panel Session: Lessons Learned from COVID-19
• Moving Forward: Chrissy Meyer
Icebreaker

Where do you wish you could be right now?

360 mountain views for me

Home is where the heart is

City-scape exploring

Lounging on a beach
Looking Back:
Key Accomplishments of the Cardiovascular Collaborative
## 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

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<tr>
<td>1.</td>
<td>Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021.¹ In Process*</td>
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<td>2.</td>
<td>Increase input into at least 4 data collection tools by organizations and/or individuals by 30% by 2021.¹ In Process*</td>
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*Integrated across other goal areas

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<td>1.</td>
<td>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 2021.² Progress: 241.4 per 100,000 (2017)</td>
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<td>2.</td>
<td>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 2021.² Progress: 48.2 per 100,000 (2017)</td>
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<td>1.</td>
<td>Decrease emergency response times by decreasing average ambulance chute times from 5.25 minutes in 2018 to 4.25 minutes by 2021.⁴ Progress: 5.23 mins (2018)</td>
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<td>2.</td>
<td>Increase the number of EMTs in South Dakota from 3,281 EMTs in 2016 to 3,850 EMTs by 2021.⁴ Progress: 3,301 EMTs (2018)</td>
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<td>1.</td>
<td>Decrease prevalence of heart attack from 4.7% (2015) to 4.45% (5% decrease) by 2021.¹ Progress: 4.9% (2017)</td>
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<td>2.</td>
<td>Decrease prevalence of stroke from 2.6% (2015) to 2.47% (5% decrease) by 2021.¹ Progress: 2.7% (2017)</td>
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## Strategies

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<tr>
<td>A.</td>
<td>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.</td>
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<td>B.</td>
<td>Promote the different models of team-based, patient-centered care (health cooperative clinic, health homes, PCMH).</td>
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<td>C.</td>
<td>Maximize community-clinical linkages (e.g. CHW, different sectors).</td>
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<td>D.</td>
<td>Support policies that increase access to heart disease and stroke care for priority populations.</td>
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<td>A.</td>
<td>Improve collaboration with tribal communities.</td>
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<td>B.</td>
<td>Utilize results of needs assessment to address infrastructure and sustainability of EMS.</td>
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<td>C.</td>
<td>Ensure utilization and sustainability of community-based resources and programs such as Mission: Lifeline, LUCAS, and pit-crew CPR for EMS services.</td>
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<td>C.</td>
<td>Identify and expand mobile integrated health programs.</td>
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<td>D.</td>
<td>Promote the cardiac ready community program to South Dakota communities ensuring at minimum 5 are enrolled in the program.</td>
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<td>A.</td>
<td>Encourage the implementation of quality improvement processes in health systems.</td>
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<td>B.</td>
<td>Promote awareness, detection and management of high blood pressure (clinical innovations, team-based care, and self-monitoring of blood pressure).</td>
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<td>C.</td>
<td>Support the expansion of prevention and lifestyle interventions in communities and for all ages across the lifespan.</td>
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Health Home Resource Hub

This resource hub has information about the foundations of team-based care, basics of South Dakota Medicaid Health Homes and building a strong team.

- Team Based Care and Health Home Resources
- Building Your Team

Building Your Team

Roles of Team Members

The size and members of a healthcare team will vary from place to place. Some Medicaid Health Homes might have five team members, while others might have two team members. The role of each team member may vary slightly due to who is on the team, however some aspects of each team members' role remain constant. Explore the South Dakota Team-Based Care Toolkit below which helps define team member roles:

- Creating High Functioning Teams

Additional Resources for Team Members:

- The Primary Care Team Guide
- AHRQ's TeamSTEPPS for Primary Care
- Core Principles and Values of Team-Based Care

Incorporating Non-Physician Team Members

The South Dakota Team-Based Care Toolkit can help guide you in how to best incorporate team members, especially non-physician team members, into your team. This includes behavioral health specialists, pharmacists, social workers, dieticians, case managers, care coordinators, and other team members. The toolkit can help you to develop the best team structure for your Health Home and learn more about the following topics:
Community Health Worker Toolkit & Webinar Series (Goal Area 2)

Why Explore this Toolkit?

Last updated August 2020

The South Dakota Department of Health presents:
A Blueprint for Success: Community Health Worker Services in South Dakota Medicaid

January 29, 2020
10:00 - 12:45 p.m. CST

The South Dakota Department of Health presents:
Leveraging CHWs in South Dakota to Improve Program Outcomes

April 21, 2020
12:00 - 1:00 p.m. CST

Register online: https://tinyurl.com/6562z5
Cardiac Ready Community Media Toolkit (Goal Area 3)

CARDIAC READY COMMUNITIES (CRC) DIGITAL TOOLKIT

*Please refrain from extracting the graphics directly from this document as they are of lesser quality. Rather utilize the graphics found in the digital toolkit folder.

Focus Area #1
Definition of a CRC
Copy: A community is made up of members who work together and build each other up – business owners, city officials, dispatchers, police, fire, and hospital staff...

A Cardiac Ready Community (CRC) is made up of members who are EDUCATED, EQUIPPED, and EMPOWERED to collaboratively handle cardiac events prior to an ambulance arriving, significantly increasing the chance of survival. Learn more about CRCs at http://kbch.sd.gov/diseases/chronic-heartdisease/cardiacreadycommunities.aspx

Hashtags: #IDCardiacReady #CRCeducation #CRCequipped

Graphic: (FA.1 – Definition of a CRC)


Recruiting Others #1
Copy: Do you live in a rural community, miles from a local hospital? Ambulances can take up to 30 minutes to get to some of the most remote parts of the state. But, what if community members could be trained to help in an emergency? Talk to your local leaders today about becoming a Cardiac Ready Community!

For more details on what a CRC looks like, visit
Media Toolkit (Goal Area 4)

- How do you limit stress?
- Find a balanced diet with dairy.
- What's a healthy blood pressure?
INTRODUCTION:

- Why is Quality Improvement in Cardiovascular Care important?
- REFERENCES
- RESOURCES

Why is Quality Improvement in Cardiovascular Care important?

1. The current state of cardiovascular disease is not where it should be.

Data collected by a variety of organizations— including the Centers for Disease Control and Prevention, American Heart Association, American Stroke Association, and the National Heart, Lung, and Blood Institute— indicates that cardiovascular disease is a major public health issue. Cardiovascular disease is the leading cause of death for people of all ages in the United States, including Hispanic Americans, non-Hispanic whites, non-Hispanic blacks, and American Indians.

Some key statistics about cardiovascular disease are:

- About 539,000 people die of heart disease in the United States every year— that’s 1 in every 4 deaths, making it the leading cause of death by disease in the U.S.
- Heart disease is the leading cause of death for people of all ages in the United States, including Hispanic Americans, non-Hispanic whites, non-Hispanic blacks, and American Indians.
- Coronary heart disease (CHD) is the most common type of heart disease, killing over 366,000 people annually.
- Every year about 720,000 Americans suffer a heart attack for the first time. Another 355,000 happen in people who have already had a heart attack.
- Heart disease costs the United States about $320 billion each year. This total includes the cost of health care: services, medications, and lost productivity.

Cardiovascular disease is also a large health issue in South Dakota.
Member Engagement Annual Survey

- **50** members completed survey
- **89%** believe they are making an impact on their community through engagement with the Cardiovascular Collaborative
- **98%** are committed to integrating the strategic priorities of the Collaborative within their organization
- **44%** have shared information in a professional setting (i.e. workplace)
- **11%** have shared information with community members (i.e. community center)

“Thank you for the opportunity to work with the Collaborative. We have made great strides and I know more exciting things are still to come.”
Take a Break!
COVID-19 Panel Discussion
Welcome Panelists

Scott Christensen
Director of Clinical Services
PatientCare EMS

Theresa Newcomb
Family Nurse Practitioner
South Dakota Urban Indian Health – Sioux Falls

Misty Rudebusch
PA-C/Medical Director
Horizon Health Care

Maynard Konechne
EMT
South Dakota Emergency Medical Services Association
South Dakota Ambulance Association

Dr. Tom Stys
Interventional Cardiologist,
Professor, Medical Director
Sanford Cardiovascular Institute
Sanford Heart Hospital

Moderated by:
Mark East
Vice President
South Dakota State Medical Association
Moving Forward
Looking Back...Moving Forward

What’s the Same?
• Heart disease is still the #1 killer of South Dakotans
• We’re focused on the right priorities

What’s Different?
• Amplified health disparities – Health equity focus
• Opportunities/challenges in telehealth/virtual medicine
• Fear of hospitals

What We Still Don’t Know
• Long-term effects of COVID-19 on the heart
• How long will this last?
• So much, much more...
What's Next?

1. Session 1
   Sep. 2nd

2. Session 2
   Sep. 9th

3. Prioritization Survey
   Sep. 9th - 16th

4. Goal Area Group Meeting
   Sep. 16th - Oct. 2nd
THANK YOU