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SOUTH DAKOTA HEALTHCARE

SUCCESS STORY

Inspiring Health and Wellness for Patients with Hypertension at Coteau des Prairies through Compass Care

Challenge

Coteau des Prairies (CDP) Health Care System partnered with the Department of Health's (DOH) Heart Disease and Stroke Prevention Program (HDSPP) team in 2019 when HDSPP offered a funding opportunity focusing on quality improvement, team-based care, and implementation and expansion of self-measured blood pressure (SMBP) monitoring. As part of their award, CDP first needed to address their electronic medical record (EMR) capabilities, as much of the work would be data-driven. CDP's EMR did not initially provide a comprehensive dashboard for easy visualization or analysis of their provider's quality measures. Once CDP's EMR provider dashboard was accessible, data needed to be reviewed for thoroughness and accuracy, an ongoing aspect of quality improvement. After establishing baseline data, clinical support and coordination of patient care across the health care team had to be streamlined for maximum efficiency and patient benefit. Lastly, CDP needed to implement SMBP, a new program to the facility. All these initiatives required staff and patient buy-in, training, and development of new work flows, policies, and processes.

Solution

Coteau des Prairies recently developed a care coordination services program and coined the name Compass Care to serve as the umbrella for all care coordination within the organization. The program began with care coordination targeted toward individuals affected by substance use disorder through coordinating medication assisted treatment and other support services for patients. An additional opportunity for team-based care through SMBP provided a catalyst for the expansion of Compass Care to provide care coordination services for a new focus group of individuals with uncontrolled blood pressure. Through Compass Care, CDP has:

- developed a workgroup to identify and map workflows to be utilized for SMBP
- created a team-based care approach through piloting the program with a physician champion coupled with a nurse, dietician and pharmacist for well-rounded patient care
- utilized feedback and expertise from the pilot program to provider further development of clear protocols for the program support through multiple disciplines.

Evidence-Based Interventions

Evidence-based strategies implemented include supporting the engagement of non-physician team members in the clinical setting and facilitating the use of self-measured blood pressure monitoring with clinical support.

Policy/System Change

There has been a new engagement and energy experienced after adopting this team-based approach. Patients have responded positively to the new patient-centered care and one-on-one coaching and the adoption of the care coordination model. Additionally, the potential for improved outcomes and engagement for both patient and staff has been a positive result of this work.

Next Steps

CDP will continue to partner with the DOH team in 2020-2021 to further build momentum around team-based care through utilization of more structured care coordination programming. To continue to expand this work, CDP will look at retrieving additional data from their EMR for an improved provider dashboard. Increasing the number of patients with hypertension who use home blood pressure cuffs, participate in medication review visits and receive nutrition counseling will all help improve hypertension control for CDP's patients. They are also working on developing a care coordinator position to further assist with chronic care management.

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