Clinical-Community Integration for Cardiovascular Disease

The VT Department of Health is partnering with GUVIST to manage a CDC grant which will advance health equity for individuals at risk of cardiovascular disease by focused strategies that are mindful of the social determinants of health. By streamlining SDOH screening with focused referrals for social needs, we aim to reduce CVD risk for populations with hypertension and/or high cholesterol receiving care at Little Rivers Health Care. System wide transformation across multiple agencies can be achieved by implementing or expanding several strategies in your organization.

Elements of a project could include:

- Identifying population with CVD risk
- Developing, standardizing or expanding tracking and monitoring of social needs
- Building and expanding network of community partners to address social needs
- Monitoring referrals to and utilization of appropriate and consistent social services in community
- Building or maximizing team based care (i.e. community health workers, care coordinators, community nurses) to mitigate social service barriers
- Reporting on health outcomes and clinical measures

The grant offers $50,000 for 4 years which can help cover the cost of personnel, IT functionality, a referral platform or self-measured blood pressure monitoring in public spaces, among other supports the team decides it needs to deliver this care.

Join us in reshaping how we care for our populations at risk of CVD and sharing this funded opportunity to build capacity and prevent clinical needs by addressing social needs.

Partners:

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