The Max Clinic – Process Map

Referral Sources:

- Case manager and medical providers
- Public health HIV/STD partner services
- Systematic review of clients fallen out of care via Data-to-Care program
- Automated information exchange with UW Medicine admitted to the hospital

Referrals reviewed by clinician, Disease Research & Intervention Specialists (DRIS), and social worker

IF ACCEPTED

Linkage to Care: Medical Case Managers (Social Workers)

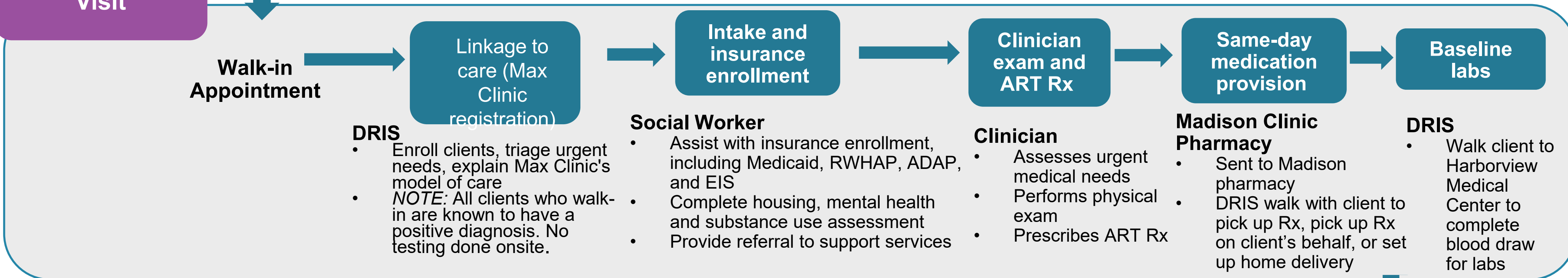
- Correspond with the client's previous case manager to coordinate a plan for transition

IF ACCEPTED

Linkage to Care: Nonmedical Case Managers (DRIS)

- Contact patients by phone and conduct outreach to potential/referred clients from community orgs or hospital/ER/Madison clinic
- Lead investigations for EDs, hospitals, jails, in which out-of-care PWH are identified

DAY 1 of Rapid Start Visit



2 WEEKS (or, as needed) after Rapid Start visit

Follow-Up Visit (nonmedical)

Social Worker

- Client comes in for housing assistance, grocery cards, supportive services as needed

Every 2 months after Rapid Start Visit

Follow-Up Visit (medical)

Clinician

- Client comes in for labs and to test viral load (will receive monetary incentive)

Follow-Up Visit (nonmedical)

DRIS/Social Worker

- Provide reminders on monetary incentives
- Provide referrals to support services as needed

RapidART Dissemination Assistance Provider

A Project of CAI