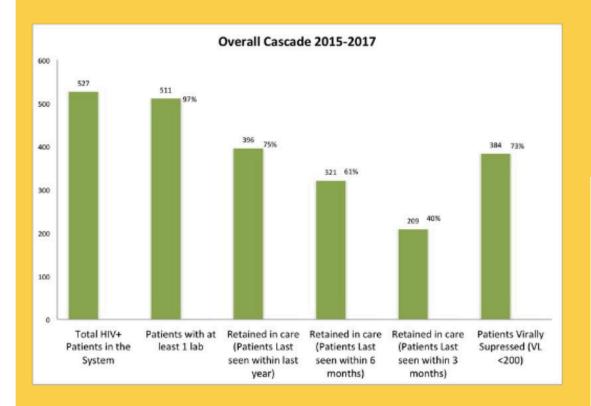
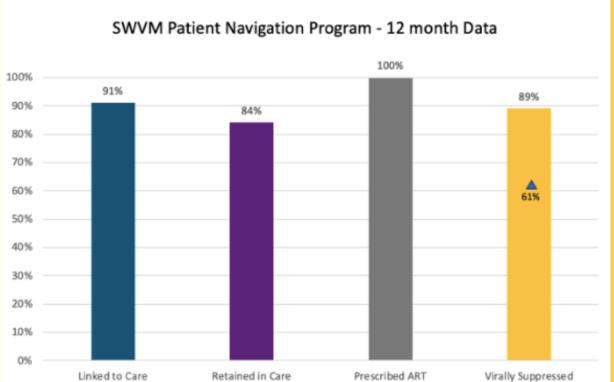


### Overview

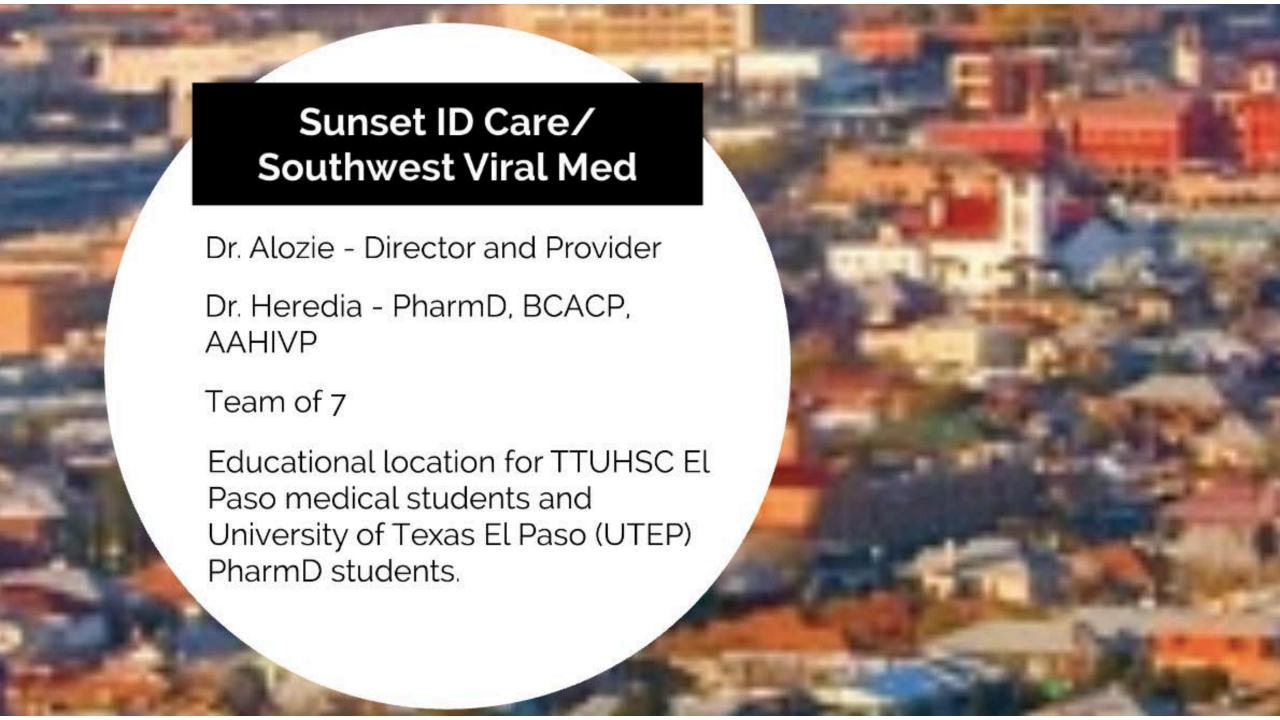




## HIV Care Continuum



61% - number calculated with at least 1 visit vs. 89% calculated from retained in care A total of 129 patients referred to SWVM from September 1, 2017- September 30, 2018







"The greatness of a community is most accurately measured by the compassionate actions of it's members" - Coretta Scott King

Teamwork

Transition of Care

# **Project CHAMPS**

- Case Management arm of the program
  - Team of 6



Health Department

UMC

Opportunity Center

Aliviane

# Transition of Care Interventions (Warm Hand-off)

Connect a patient to the provider or case management program directly from the referring hospital.

Initial referral from the hospital

Hospital visit by the patient navigator Transition of care interventions

Usually followed by a second hospital visit, home visit or both **Brief Questionnaire** 

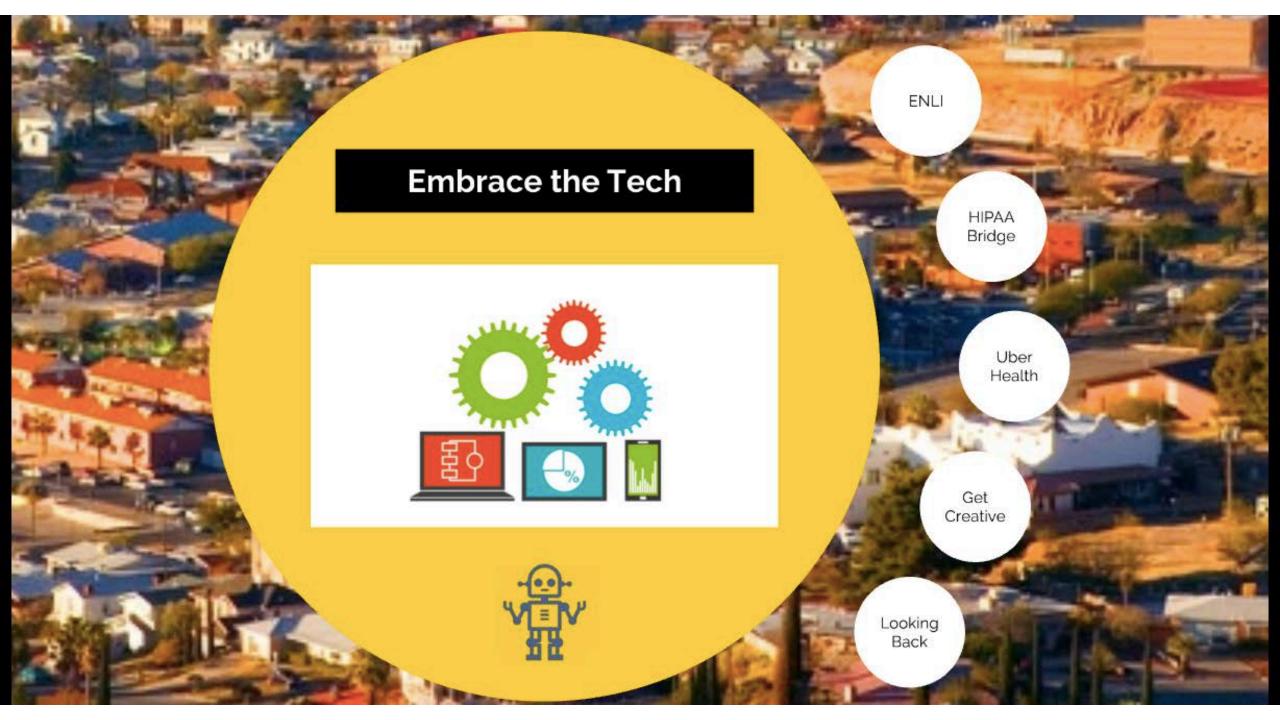
Identify potential barriers

Provide RW registration materials at hospital

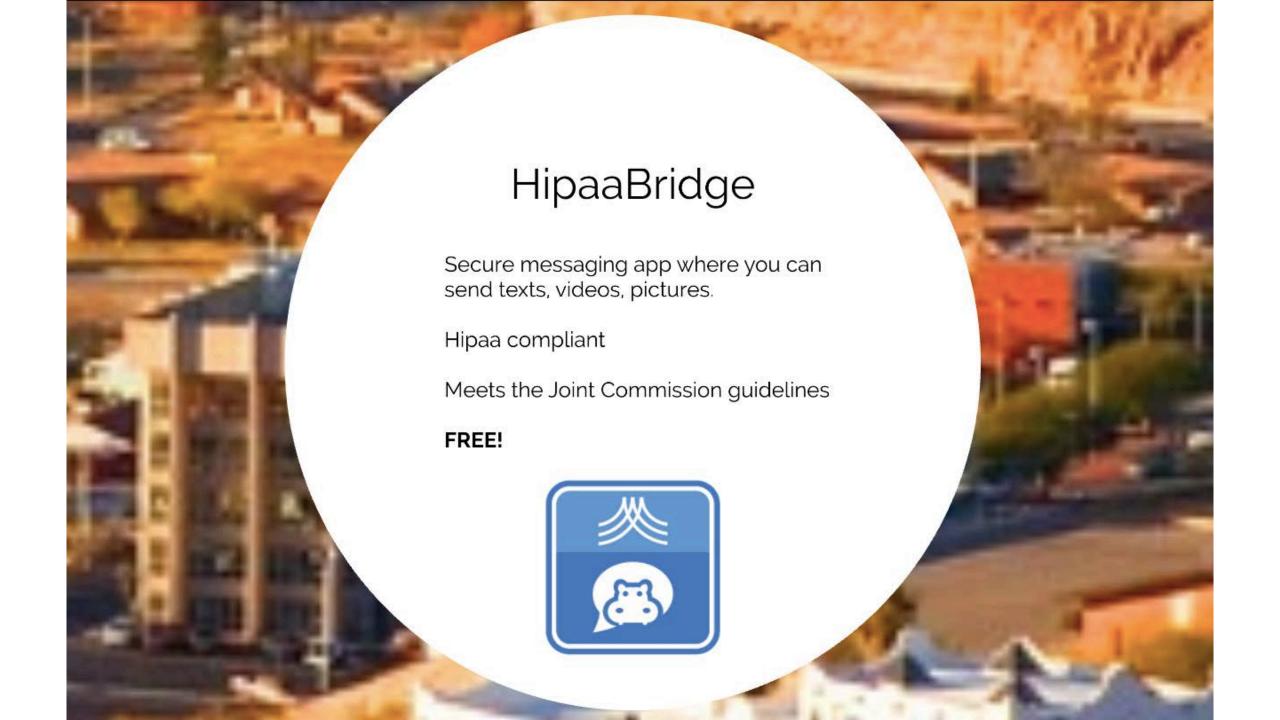
Schedule two appointments (CM and provider)

Ensure records are sent

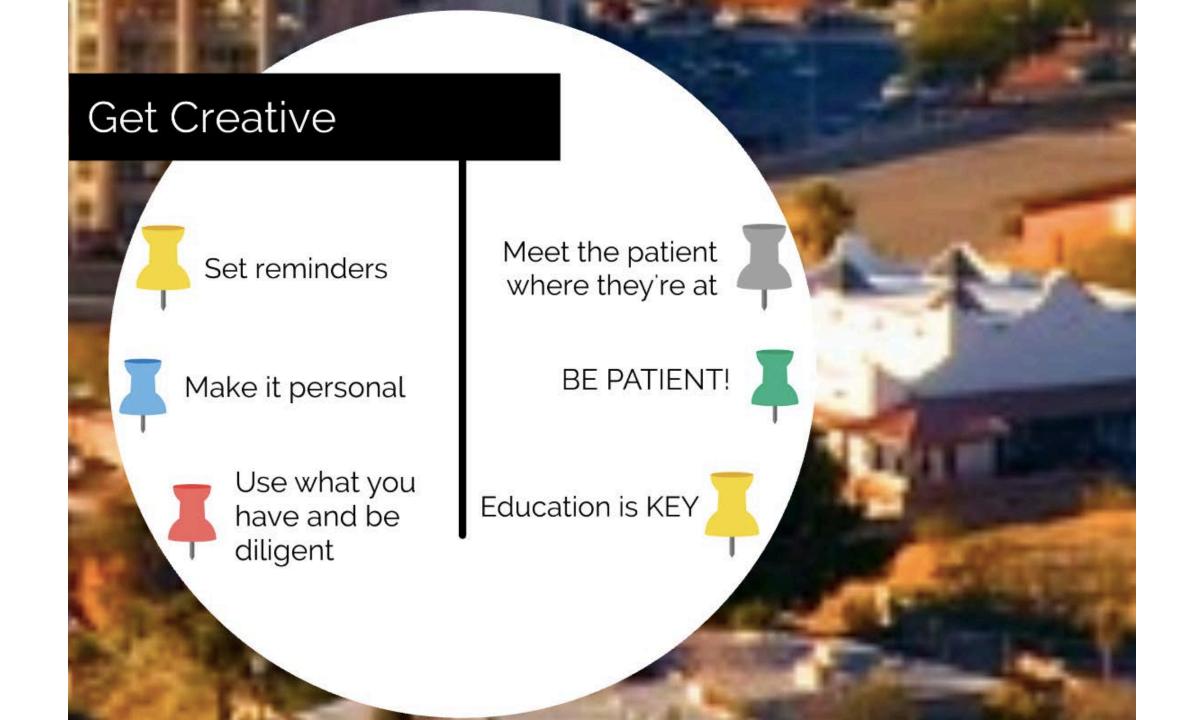
Medication list

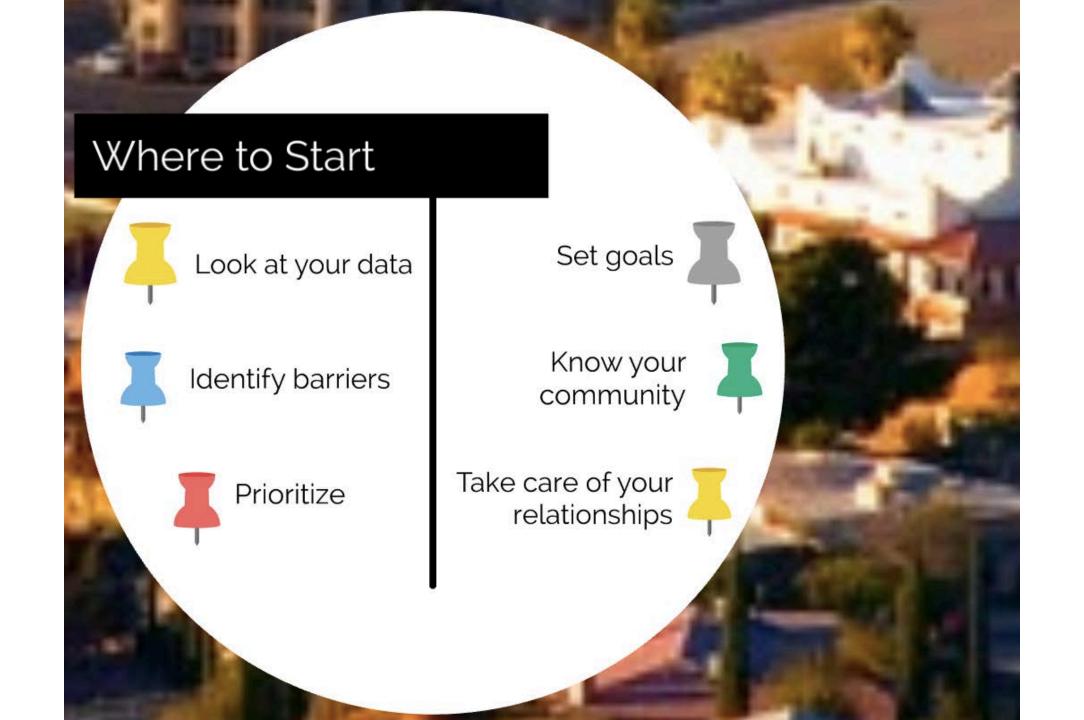












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