

The purpose of this document is to provide resources and information to support HIV health care practitioners' efforts to retain HIV-positive people in medical care. Ensuring that people with HIV have access to HIV primary care is a cornerstone of both New York State's Ending the Epidemic Blueprint and the National HIV/AIDS Strategy. Persons engaged in health care have better health outcomes such as improved viral suppression, which helps patients live longer and healthier lives and avoid transmission of the virus.

On April 1, 2014, Public Health Law Section 2135 was amended to promote linkage and retention in care for HIV-positive persons. The law allows the New York State Department of Health (NYSDOH) and New York City Department of Health and Mental Hygiene (NYC DOHMH) to share information with health care providers for purposes of patient linkage and retention in care. The NYSDOH AIDS Institute recommends that health care providers take a multi-pronged approach to support their patients' retention in care, including but not limited to the following:

Have a proactive patient plan: Do not wait for a lapse in care to discuss what to do if the patient becomes lost-to-care.

- Create a patient-centered atmosphere, where all members of medical care teams (e.g., reception staff, phlebotomists, medical providers, etc.) promote patient engagement, linkage, and retention in care.
- When acceptable to patients, expand authorization dates on **Authorization for Release of Health Information and Confidential HIV-Related Information** forms (DOH-2557) to at least 2 years. Extending consent timeframes allows collaboration across sectors.
- Have DOH-2557 consent forms on file for every patient. This will permit you to contact community based organizations (CBOs) and others in the event of a lapse in care. Examples of CBOs that can help return patients to care include but are not limited to: HIV/AIDS CBOs; Health Homes and their downstream providers; food and nutrition programs; shelters; substance use treatment facilities; housing providers; mental health providers; prenatal care providers, etc.
- Encourage patients to add your practice's name to any releases they sign with other organizations.
- Work with patients to update releases prior to when the releases expire (if applicable).
- Become a member of your area's Health Home network(s) if you have not already done so.
 - for more information go to:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

Leverage existing resources for patient re-engagement.

- Use information from the Regional Health Information Organization (RHIO), if available, to determine if the patient is in care with another provider or if updated personal contact information is available.
- Conduct a health insurance benefits check, if available, on the patient to determine if s/he changed insurance or is in care with another provider.
- If the patient is in a Managed Care plan, the plan will have updated contact information, recent use of care, and medications on file. If this is a Medicaid Managed Care Plan, the plan can identify which Health Home the patient may be enrolled in and this information may be useful to your follow-up efforts.
 - If your patient is enrolled in a Health Home and has signed a release, contact the Health Home to determine whether the patient is actively enrolled. If yes, request assistance to contact or re-engage the patient in care.
 - If your patient has Medicaid but has not been enrolled in a Health Home, contact the Health Home to make an "upstream referral." The patient will be referred to a provider who may conduct outreach to the patient's home.
- Try multiple modes of contact (phone, text, letter, email, and social media) at varying times of the day/week to reach the patient (special consideration for social media sites – contact patient from an agency social media account and not a staff person's personal account).
- If your patient uses other services within the facility (e.g., WIC, dental, child's provider), place an alert on the Electronic Medical Record (EMR) to reconnect to the HIV Primary Care Provider and, if pregnant, to her prenatal care provider.
- As authorized in patient releases and/or medical charts, work with emergency contacts and other agencies/providers to determine whether they have had recent patient contact.
- Conduct a home visit if resources allow. If you have a peer program, utilize peers to provide outreach to the patient's home.

Use external systems to expand your search when you cannot find a patient.

- Review public records such as:
 - Property tax rolls, municipal tax rolls, etc.: <http://publicrecords.onlinesearches.com/NewYork.htm>
 - Parole Lookup: <http://www.doccs.ny.gov/lookup.html>
 - NYS County Jail inmate lookup: <https://vinelink.vineapps.com/login/NY>
 - NYC Department of Corrections inmate lookup: <http://www1.nyc.gov/site/doc/inmate-info/inmate-lookup.page>
 - NYS Department of Corrections and Community Supervision Inmate lookup: <http://nysdoccslookup.doccs.ny.gov/>
 - Consider using people search engines, local newspapers, and police blotters.
- Social Security Death Master File Portal: <https://www.npcrcss.cdc.gov/ssdi/>
(A user ID and password are required to access the site and may be obtained by calling (301) 572-0502.)

Pregnant women and exposed infants lost-to-care require immediate action for re-engagement.

HIV-positive pregnant women and their exposed infants are a priority when identified as lost-to-care and require immediate action for re-engagement. Reengagement in care is especially important for HIV-positive pregnant women who are in their third trimester due to possible increasing viral loads from being non-adherent to ART, leading to increased risk of transmitting HIV to their infants. Ensuring exposed infants are engaged in care is critical during the first 4-6 months to ensure appropriate antiretroviral and opportunistic infection prophylaxis, as well as definitive documentation of the infant's HIV infection status.

If routine attempts for reengagement of the HIV-positive pregnant woman or her exposed or infected infant(s) are not successful, please contact the NYSDOH Perinatal HIV Prevention Program at (518) 486-6048 or submit a request via the NYSDOH HIV/AIDS Provider Portal (see below) for assistance. NYC providers should call the NYC DOHMH Field Services Unit at (347) 396-7601 for assistance with reengagement of pregnant women.

NYC-based providers (located within the 5 boroughs):

Eligible NYC providers with patients who have been out-of-care for 6 months or longer can use the NYC DOHMH's HIV Care Status Reports System (CSR) to obtain information on patients' current care status in NYC. Information from the CSR may be useful to your follow-up efforts.

For more information, see <https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv-care-status-reports-system.page>

Eligible NYC providers may also call the NYC DOHMH Provider Call Line at (212) 442-3388 to obtain information that may help link or retain patients in care.

For providers based in NYS outside of NYC:

After exploring the investigation tools and strategies listed above and if patient follow-up is warranted, the Bureau of HIV/AIDS Epidemiology (BHAIE) may be able to provide information regarding a patient's care status through the NYSDOH HIV/AIDS Provider Portal. The HIV/AIDS Provider Portal is an electronic system which enables clinicians to: 1) meet their reporting requirements electronically; 2) provide a mechanism for clinicians statewide to notify the NYS DOH that a patient needs linkage to Health Department Partner Services; and, 3) submit inquiries for patients with diagnosed HIV infection who are thought to be in need of assistance with linkage to or retention in HIV medical care. A NYSDOH Health Commerce System (HCS) Medical Professionals account is required. To apply for an HCS Medical Professions account, navigate to: <https://apps.health.ny.gov/pub/top.html>.

After logging into the HCS at <https://commerce.health.ny.gov/>, select "Refresh My Applications List" on the left side and then under "My Applications" select HIV/AIDS Provider Portal. Follow the prompts to set up an account. Urgent requests will be responded to within 1 business day. For routine requests to the HIV/AIDS Provider Portal, the turn-around time is typically within 1-3 business days.