CAROLINA FAMILY HEALTH CENTERS, INC.
PROCEDURE

TITLE: RW-100.09 Re-Engagement of HIV Patients

EFFECTIVE DATE: June 6, 2023

SECTION: Ryan White
REFERENCE POLICY: RW-100 Ryan White Program

RESPONSIBLE CHIEF OF STAFF: Chief Medical Officer
RESPONSIBLE COMMITTEE: Medical CIT

REVIEWED:

I. PURPOSE

The purpose of this procedure is to identify patients who do not keep or miss appointments (i.e., disruption in HIV care) and work towards engaging the patient back into care at Carolina Family Health Centers, Inc. (CFHC, Inc.).

II. PROCEDURE

In attempts to minimize disruption in care, CFHC, Inc. provides appointment reminders via telephone, text message, email, or through the patient portal directly to patients for upcoming patient appointments. The frequency and duration of these reminders for people living with HIV (PLWH) are consistent with procedures for the organization.

Additionally, CFHC, Inc. provides accessibility to appointments by maintaining multiple providers of HIV care and at multiple locations.

To reduce the likelihood of disruption in care for PLWH, CFHC, Inc. maintains the following process to reengage patients and gain an understanding of the barriers the patients may experience.

- Staff contacts patients who have not kept their scheduled appointment on the day of the missed appointment.
- Contact with patients can be made through (in order of priority) a telephone call, a patient portal message, or a letter.
- Home visits may be made to assist returning a patient to care.
- Staff utilize available resources to determine if the patient is deceased or incarcerated.
- Three attempts are made within 30 days to contact the patient to re-engage them in care.
- Any contact attempt is performed three to five days apart.
- Multiple contacts in the same day are considered one attempt.
- All efforts to contact a patient are documented into the patient's electronic medical record.
- Transportation is offered to all patients
- Staff can access *Care Everywhere* in the electronic health records or the Health Information Exchange

If staff efforts are not successful in reconnecting with patients who have not kept or missed appointments after the 30 days of attempts, a referral is initiated in CAREWare to the regional bridge counselor in North Carolina. The bridge counselor attempts to locate patients lost to care and communicates findings through CAREWare. Ryan White staff review the bridge counselor findings within 30 days of the referral and documents the findings in the electronic health record.

If the patient has not been seen by a medical provider in 180 days, the patient is considered lost to care and no additional future attempts to reconnect into care are made.