University of Illinois College of Medicine

Heart of IL HIV/AIDS Center

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HIHAC Overview

- HIHAC received first HRSA grant 10/1993 and opened January 1, 1994
- Located in Central Illinois. Provides care to persons from 15 counties
- HIHAC receives funding through 7 Grants and Contracts
- In 2009 HIHAC served 533 people
- Departments – Medical, Social Service, Education and Outreach, and Administrative Support

HIHAC Services

- Services include:
  - Primary medical care
  - Mental Health counseling
  - Nutritional assessments
  - Food vouchers
  - Transportation vouchers
  - Rent and utility assistance
  - Emergency financial services
  - Free anonymous/confidential HIV testing and counseling
  - Risk reduction supplies
  - Support Groups

HIHAC Quality Assurance

- QA projects began in 1999
- Enrolled with HIVQUAL in 2002
- Began with basic HRSA Indicators
- Registered Nurse and Director have been through the NY State National Quality Centers TOT Training
- Committee Members: Medical Director, Medical Coordinator, HIHAC Director, Nursing Staff, Social Service Coordinator. Consumer will be added 09/2010

Plan Do Study Act

PDSA ~	Start	Score	End	Score
Increase Patient Retention	2007	40%	2009	76.2%
Increase PPD Screening	2005	46.2%	2010	72.5%
Increase Lipid Screening	2007	52.8%	2010	90%
Improve/maintain consumer satisfaction scores	2008	21%	2009	34%
Increase PAP for “eligible” women	2003	50.9%	2010	79.2%
Increase BIA Screening	2008	3.9% (21 pts)	2010	28.5% (152 pts)

**Data in this table come from the HIVQUAL annual audit tool on random sample of patients enrolled.*

Patient Retention

- Problem: chronic “no-shows”
- Several attempts to resolve “N/S”
  - All patients given reminder call day before scheduled appointment.
  - Nurses called clinic day after missed appt
  - Flag placed in the medical chart when appt was missed
  - Scheduled chronic “N/S” appointments at the end of the day
  - Finally Developed PDSA ☺

Patient Retention PDSA

- “Retention”-patient must be seen by a Primary Care Provider every 6 months.
- Created monthly reports of patients not seen within the last 6 months.
- Reviewed case management records of No-Shows. FINDING: Clients who N/S for medical appts. still coming in monthly to receive case management resources, i.e. food voucher, bus pass, gas card and many regularly engage with Outreach Dept.
- Discussed options to re-engage clients into care:

Decision:

1. Medical Case Managers (MCM) and Outreach workers will work with clients to encourage their return to care.

2. Social Service resources will be provided to client when they arrive for the scheduled medical appointment

Summation

The Center would never withhold resources from clients in emergent need. However, the results from limiting resources until clients come in for labs and follow-up with the PCP at least two times per year, appear to have a positive outcome by keeping clients engaged in their care and subsequently, out of the hospital.