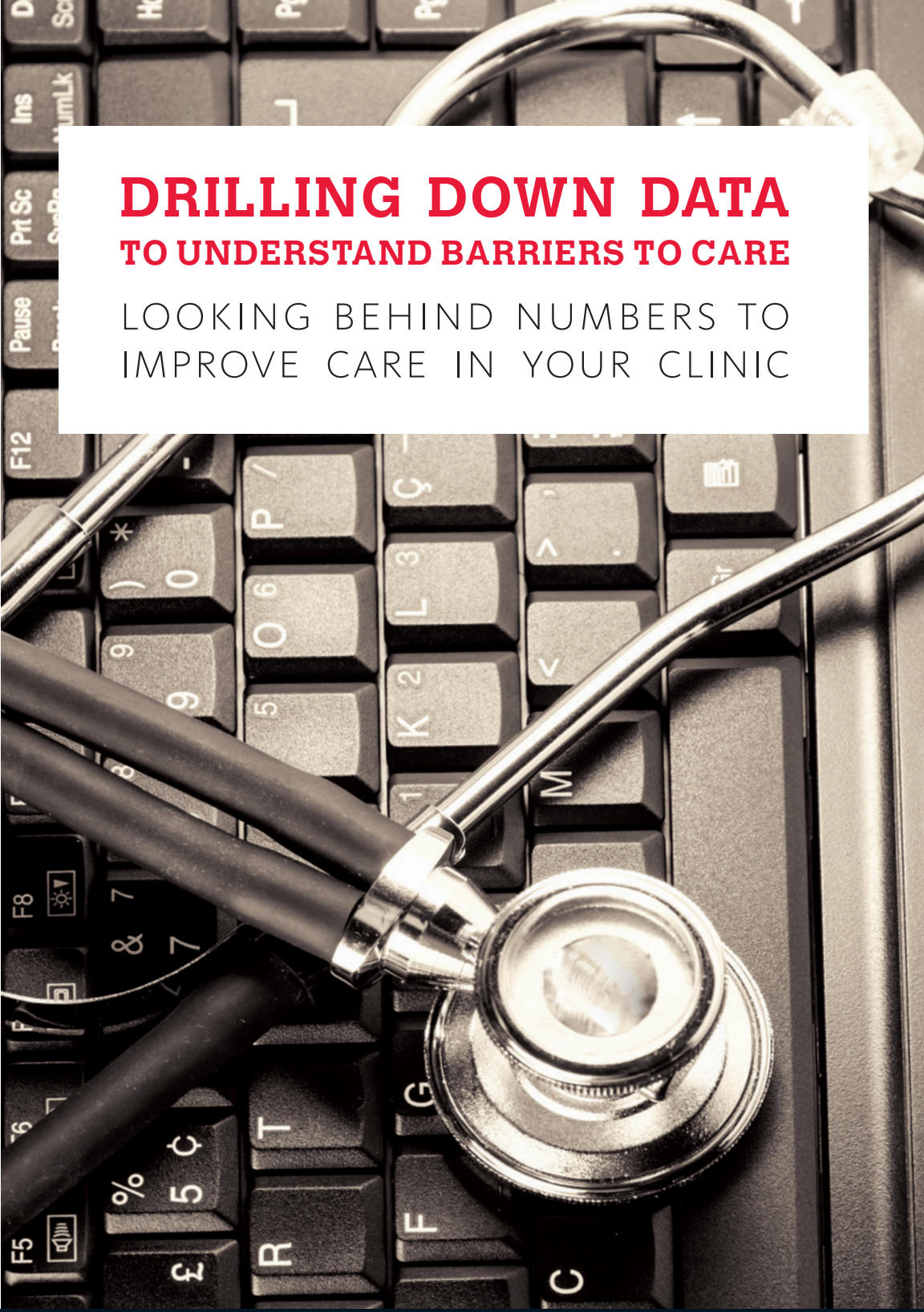

DRILLING DOWN DATA

TO UNDERSTAND BARRIERS TO CARE

LOOKING BEHIND NUMBERS TO IMPROVE CARE IN YOUR CLINIC

NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE

PRIORITIZATION STRATEGIES

To most effectively target your resources to those in need, consider prioritizing follow-up interventions by clinical information, patient characteristics, and service utilization.

For example, you can assess by:

- **Viral load.** Using the most recent viral load measurements on record, calculate the average viral load among all patients experiencing each barrier. The highest average viral loads can be used to help your facility identify the patients and barriers on which to focus. Keep in mind that one patient with an abnormally high viral load can skew the average. Be sure to closely examine the data to evaluate whether clinic-wide or individualized interventions will be most appropriate.
- **Key populations.** Assessing problems by subpopulations (men who have sex with men (MSM), women, transgender populations, injection drug users, sex workers, those with unstable housing, prisoners, etc.) can help identify groups most in need of interventions and can help you design the most appropriate interventions for each population.
- **Those with frequent hospital and emergency department use.** Identifying reasons why individuals frequently use hospital and emergency department resources in place of routine medical visits can help engage these patients in your clinic and ensure that resources are used efficiently.

EXAMPLES:

PRIORITIZING BY AVERAGE VIRAL LOAD:

BARRIER	NUMBER OF PATIENTS	AVERAGE VIRAL LOAD (COPIES/ML)
TRANSPORTATION	10	290
HOUSING INSTABILITY	4	1,580
INSURANCE	1	74
DISCLOSURE ISSUES	13	5,439
REFUSES TREATMENT	1	30,982

IDENTIFYING BARRIERS TO RETENTION AMONG MSM:

KEY POPULATION	BARRIER	NUMBER OF PATIENTS
MEN WHO HAVE SEX WITH MEN (MSM)	TRANSPORTATION	4
	HOUSING INSTABILITY	6
	INSURANCE	1
	DISCLOSURE ISSUES	11
	REFUSES TREATMENT	1

IMPORTANT REMINDER

✔ Drilling down data is not a one-time activity, but a continuous process to measure and sustain improvement in patient care. Be sure to regularly update your active patient list. Data should be updated and refreshed at least quarterly.

WHAT IS DRILLING DOWN DATA?

Drilling down data is a process of analyzing your patient care data in increasing detail to understand who is meeting performance measures and who is not. Through this process, key patient populations in need of attention and the barriers most relevant to these populations can be identified, which enables you to design population-specific and individual patient-specific interventions while efficiently targeting your resources.

By focusing on those patients most in need and tailoring follow-up activities to best meet those needs, your clinic will be more likely to achieve improvement and use resources wisely. Reaching out to patients in a way that meets their specific needs can foster ongoing relationships that improve overall engagement in care.

4 MAIN STEPS TO DRILLING DOWN DATA:

1. Develop a list of patients who do not meet the defined criteria of your measure.

2. Identify reasons each patient does not meet the criteria.

3. Tally the reasons.

4. Develop targeted plans to address the most common or relevant issues.

WHY DRILL DOWN DATA?

Data can reveal important information about barriers to care experienced by your patient population. With simple analysis of your data, you can identify areas for improvement and develop targeted plans to address those areas. In the following panels, a step-by-step method of drilling down your data is presented. This process can be used for any measure of patient care, but retention is the example used throughout this brochure.

WHY DRILL DOWN DATA?

Engaging your multidisciplinary team to regularly collect and drill down data is the most effective way to elucidate the reasons why standards are not met in specified populations and to develop follow-up plans. This team may include physicians, case managers, nurses, social workers, pharmacists, peer navigators, the data team, or any other clinic staff involved in providing care for the patient. Regular (e.g., weekly, monthly, or quarterly) team meetings for case review should occur to maintain involvement of all team members, share information and patient status updates, and identify areas for improvement.

FOUR STEPS TO DRILLING DOWN DATA

EXAMPLE: ASSESSING PATIENT RETENTION

1 IDENTIFY PATIENTS WHO ARE NOT RETAINED

Compile a list of patients who have not been seen during the time period used to define retention. Remove those from the list who meet the exclusion criteria.

EXAMPLE:

EXCLUSION CRITERIA: The patient has died, transferred care, is incarcerated, or has been admitted to a long-term or residential care facility. These patients should be removed from your denominator.

1012	⇨	56	⇨	19	⇨	37
Total patient case load		Original list of not-retained patients		Excluded: known status *(e.g., died, transferred care, incarcerated)*		Remaining list to drill down

The remaining group of patients are those to include in the drill down process.

2 ASSESS REASONS FOR NON-RETENTION

For those patients not retained, conduct an assessment of the factors causing absences from care. Multidisciplinary provider teams should review all available information from patient records as needed to identify any barriers to care, competing patient concerns, and other reasons for non-retention.

EXAMPLE:

MULTIDISCIPLINARY TEAM MEMBERS:
Case managers, patient navigators, pharmacists, nurses, physicians, others involved.

PATIENT RECORDS:
Medical records, case manager or patient navigator notes, emergency room records, correctional facility records.

3 CREATE A TABLE

Compile all the identified reasons for non-retention and tally the number of patients experiencing each. This table will be used to prioritize areas in need of improvement and to develop targeted interventions.

EXAMPLE:

KEEP IN MIND: Patients grouped in the same category may have different reasons for experiencing that difficulty. For example, patients experiencing issues with transportation may not be able to pay for fares, may live too far from available transit, etc. Individualized solutions will likely be required for each patient.

BARRIER	NUMBER OF PATIENTS
TRANSPORTATION	35
HOUSING INSTABILITY	11
INSURANCE	2
DISCLOSURE ISSUES	15
REFUSES TREATMENT	2

4 DEVELOP A TARGETED FOLLOW-UP PLAN

Using the data from steps 2 and 3, identify the barriers that are most critical to patient health and that affect the most patients. Develop a plan to address these issues. Consider prioritizing your follow-up strategies by examining the needs of key populations or by looking at health indicators such as average viral load (see *Prioritization Strategies*).

EXAMPLE:

1. One clinic identified incorrect contact information as a major barrier to retention among its patient population. Staff searched Medicaid and pharmacy records for updated contact information and visited the patient's home if they were unable to locate the individual through other means.

2. This clinic also identified transportation as a barrier to retention for one patient with a very high viral load. Staff members arranged transportation to the clinic for this patient, which proved important in engaging the patient in care (see HIVQUAL Brief 11, *Improving Patient Retention in Western New York* for more information).

✔ HELPFUL TIPS:

- **Designate a person** or team to manage the drill down process and ensure that it is repeated at regular time intervals.
- **Set a regular process for discussing and presenting data** to staff and at regular committee meetings.
- **Involve peers** in discussions, especially concerning strategies to address stigma.
- **If using an electronic system, create a routine report template of patients who do not meet the standard measured by the indicator.** Set it to run at regular intervals; for example, immediately after the end of the month.
- **For follow-up with patients:**
  1. **Establish a protocol for contacting patients**; i.e., determine the most effective methods of contact.
  2. **Establish a time frame for follow-up** as well as a minimum and maximum number of attempts for follow-up.
  3. **Document** contact and follow-up attempts, dates, and results.
  4. **Determine a policy for patients who are not successfully contacted** within the follow-up time frame.

RESOURCES

Further Reading

- NYSDOH AIDS Institute brochure, *Do You Know Where Your Patients Are? Using an Active Patient List to Monitor Patient Retention in HIV Care and Improve Health Outcomes*: **www.hivguidelines.org/wp-content/uploads/2015/02/do-you-know-where-your-patients-are.pdf**

Resources for Locating Patients

- Locating inmates in New York State (similar resources exist for other states and counties): **nysdoccslookup.doccs.ny.gov**
- Locating federal inmates: **www.bop.gov/inmateloc**
- Locating vital records (birth, death, marriage, and divorce records): **www.health.ny.gov/vital_records**; **www.vitalrec.com**
- Free general location tools: **www.zabasearch.com**; **www.411.com**

Case Studies

- NQC HIVQUAL Brief 11, *Improving Patient Retention in Western New York*: **www.nationalqualitycenter.org/index.cfm/5847/84446**
- Early Intervention Research Institute, Utah State University, *Drilling Down to Understand Outcome*: **www.eiri.usu.edu/projects/champions/factsheets/DrillingDownOutcome5.pdf**