Show me the Data!
Drilling Down on the Data

Clinical Quality Management Committee Meeting
October 22, 2021
Prepared by:
Behavioral Science Research Corporation

Behavioral Science Research

Act Plan Study Do CQM Program
Ryan White Part A/MAI
Miami-Dade County

Miami-Dade County

Objectives

Understand	the ways you can analyze data to provide the direction for your quality improvement efforts and comply with Policy Clarification Notice (PCN) 15-02.
Review	how to drill down data and useful quality improvement tools.

What is Drilling Down Data?

- Drilling Down Data is a process of analyzing your client level data in detail to understand who is meeting the performance measures and who is not.

4 main steps to Drilling Down Data:

1. Develop a list of clients who do not meet the defined criteria of the performance measure (request CIS#s from BSR if necessary).
2. Identify reasons each client does not meet the criteria.
3. Tally the reasons.
4. Develop change ideas (plans) to address the most common issues.

**New York State Department of Health AIDS Institute*

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).

**New York State Department of Health AIDS Institute*

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

Step 2 Assess Reasons for Non-Retention

For those patients not retained, assess the factors causing absences from care. Teams should review client records to identify barriers to care or other concerns for non-retention.

EXAMPLE:

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Step 4 Develop a Targeted Follow-up Plan

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Prioritizing Populations Based on Your Data

Viral load- Using the most recent viral load measurements in Provide Enterprise Miami, calculate the average viral load among all clients experiencing each barrier. The highest average viral loads can be used to help your agency identify the patients and barriers on which to focus.

Barrier	Number of Clients	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

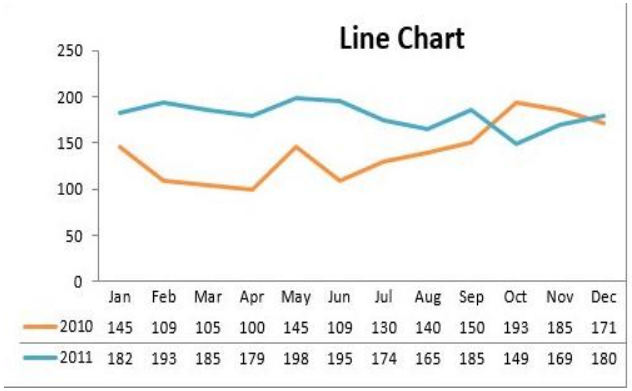
Subpopulations. Identifying subpopulations that may include male to male sexual contact (MMSC), females, clients with unstable housing, and substance abusers to help identify key groups most in need of interventions.

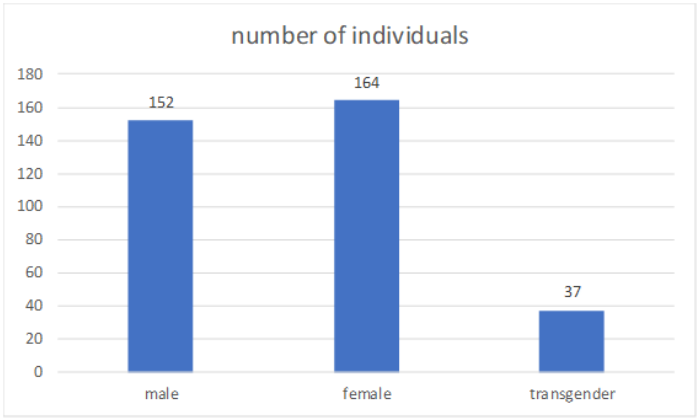
Key Population	Barriers	Number of Clients
African American MMSC	Transportation	4
	Housing Instability	6
	Insurance	1
	Disclosure Issues	11
	Refuses Treatment	1

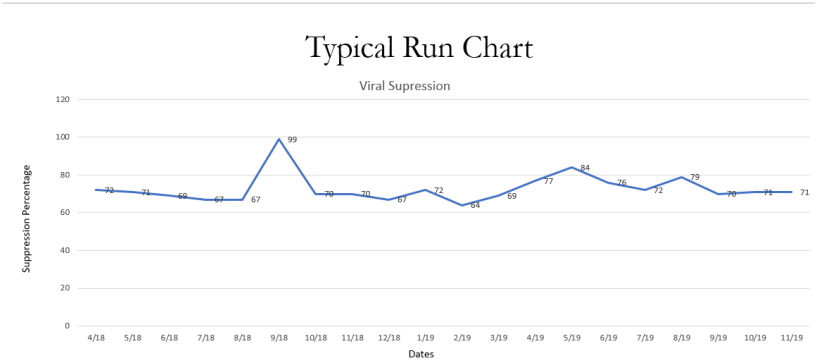
Potential Sources of Data

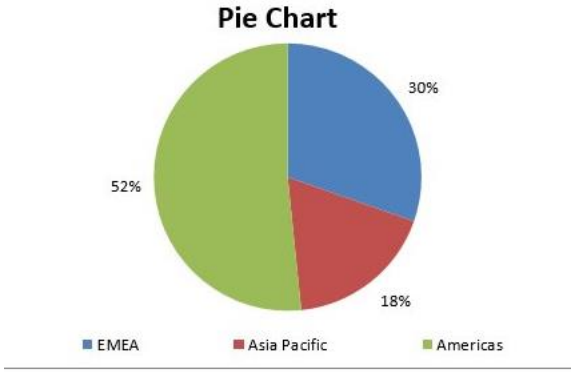
- Provide® Enterprise Miami
- Internal Electronic Health Record
- Tracking Sheets
- Client Record Reviews
- Check lists
- Client Satisfaction Surveys
- Focus Groups
- Dashboards
- Client Interviews

Let's Review Tools







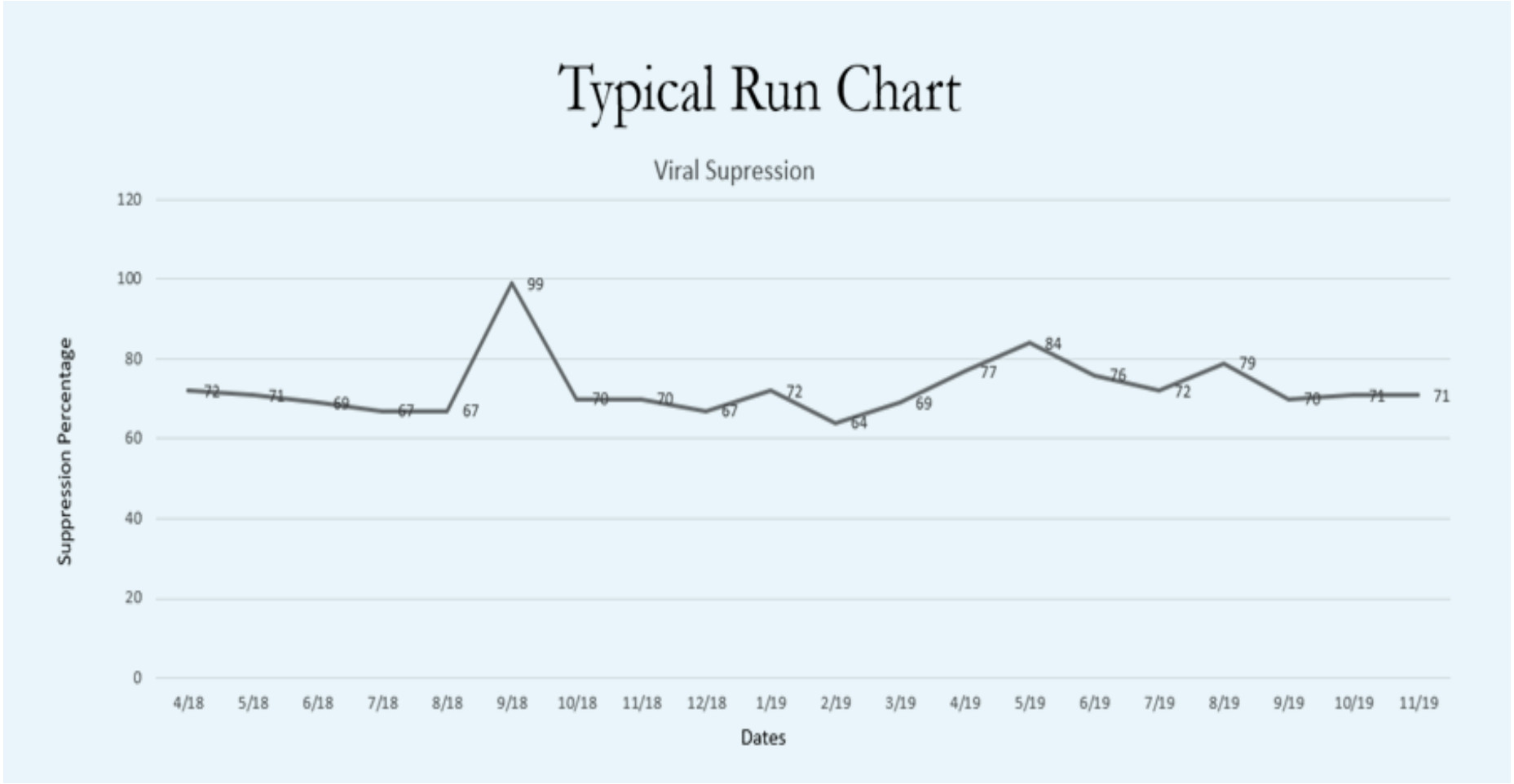


Run Charts

When to Use a Run Chart

- A line chart connects observations or data points with a solid line
- Usually show time series data
- They illuminate trends in data
- Collect a minimum of 10 data points over time
- Make the data collection periods consistent
- Only have data relevant to that which you are measuring

What Do you See?



** Center for Quality Improvement & innovation*

Pie Charts

When to Use a Pie Chart

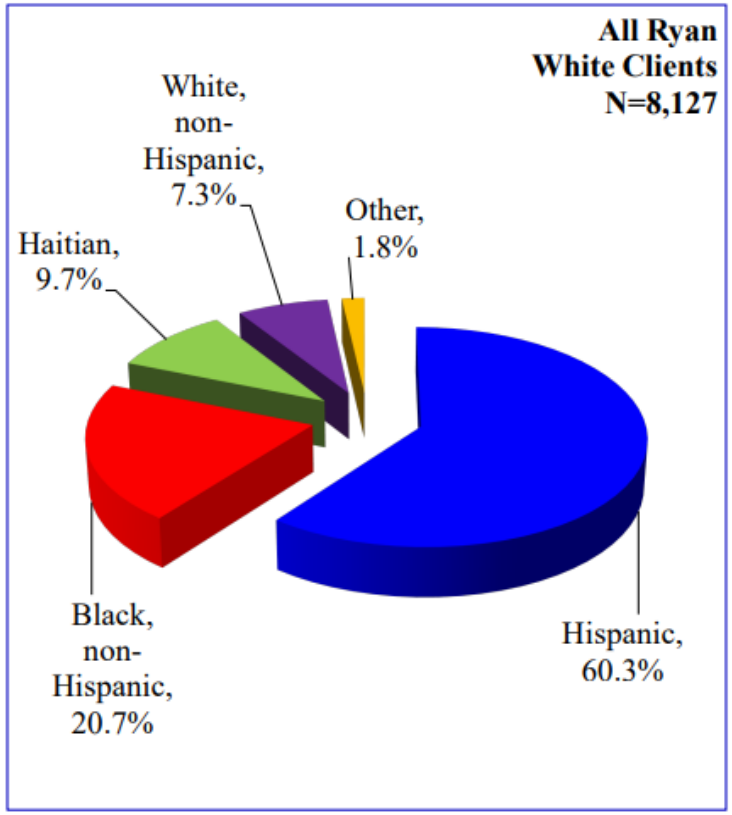
Do you have one variable to compare (race, age, gender)?

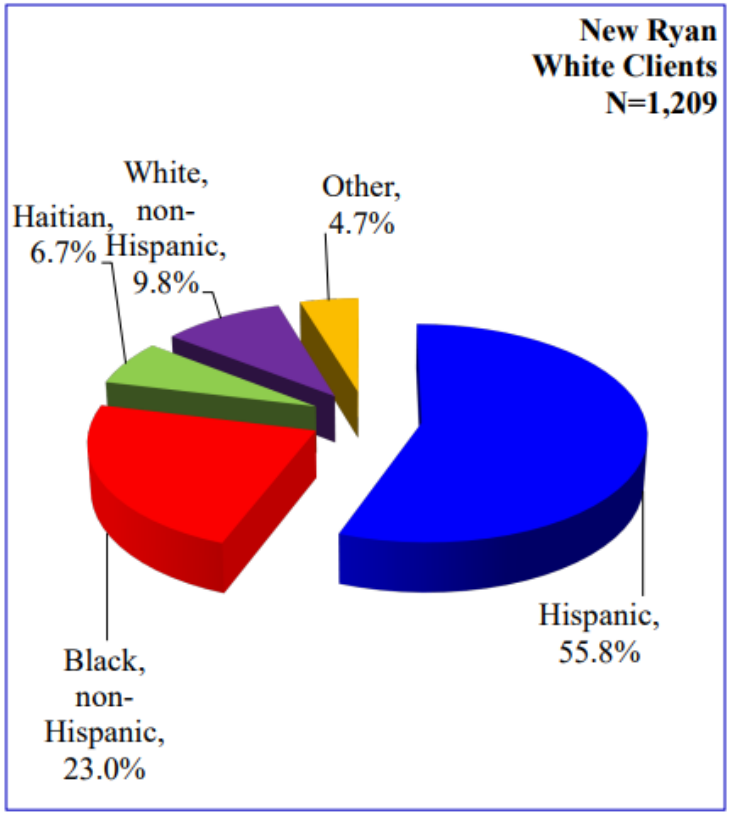
Do you want to sort data in categorical groups? (limit categories to 7 or less)

Each slice expresses a part-to-whole relationship in your data.

What Do you See?

Race/Ethnicity Distribution of New and Total Client in Care
Ryan White Program, FY 30





Bar Chart

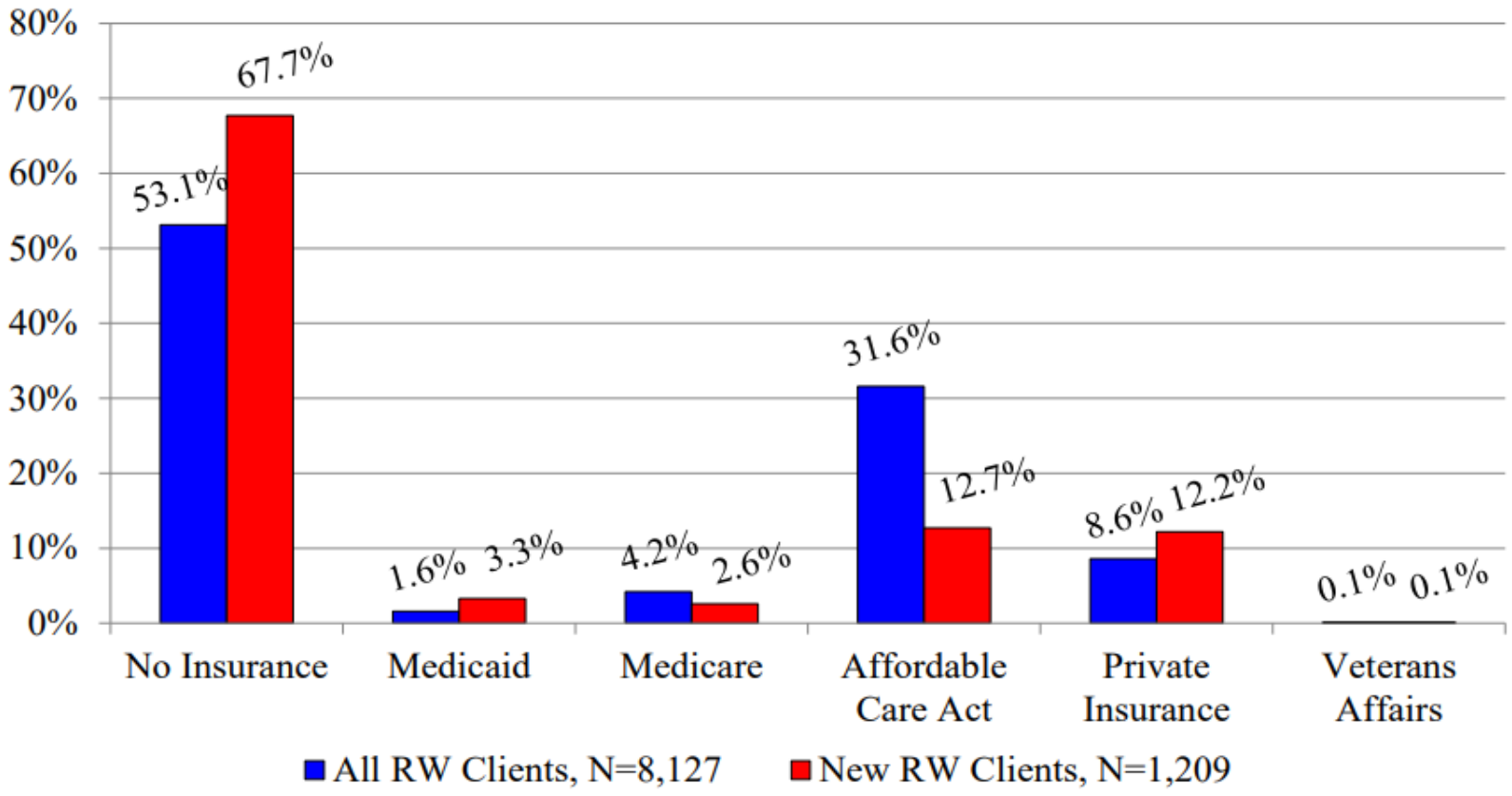
Bar Chart

Bar charts use categories on their X axis; frequency of occurrence on the Y axis

They are used to compare different categories of data (e.g., patient breakdown)

What Do you See?

Insurance Coverage of New and Total Clients in Care Ryan White Program FY 30



Checklist

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Simple tool to capture repetitive activities that may include:

a) Reasons clients did not show for PCP appointment

b) Number of Action Plans Completed

Organizes your data to use for graphical analysis

Captures quantitative (# of suppressed clients) or qualitative (focus group) data

What do you see?

Checklist Example
Reasons for "No-Shows"

	Monday	Tuesday	Wednesday	Thursday	Friday	Total
No transportation	1		1		1	3
No child care		1		1		2
Bad weather	1					1
No fare money	1	2	1	3	1	8
Could not miss time from work	1			2		3
Other priority that day						0
Forgot		1				1
Feeling good; no need to go					1	1
Other; list below						
too sick to come in			1			1


QUIZ
TIME!

Let’s Recap

Basic Questions to Ask of Data

What are the sources of the data?

Are there any patterns in the data that have implications for the way we provide services?

Do numbers go up or down for specific populations of interest?

How can I use this data to improve client health outcomes and or client satisfaction?

Next Steps

Ryan White Program MCM Subrecipients will Drill Down their Data and identify a target subpopulation.

MCM subrecipients will identify the baseline measure for the target population.

BSR CQM staff will be available to assist with drilling down data.

Resources for your QI Toolbox

- **Drilling Down Data to Understand Barriers to Care-Looking Behind Numbers to Improve Care in Your Clinic** https://quality.aidsinstituteny.org/Areas/QualImprove/Files/2019/d_20190315/3-15-19-3.b.%20QI%20Drilling%20Down%20Data%20Full%20PDF.pdf
- **Choosing an Improvement Project Lesson Set (3 Part Course)**

  https://targethiv.org/library/cqii-choosing-improvement-projects
- **Institute for Healthcare Improvement (free tutorials on QI)** http://www.ihi.org/Topics/ImprovementCapability/Pages/default.aspx?gclid=EAIaIQobChMIrsa2oODZ8wIVjqjICh2F-ANVEAAYAiAAEgKo0PD_BwE


QUESTIONS


Thank
You
Asante
Dank Je
Matondo
Spasibo
Merci
Mulțumesc
Vinaka
obrigado
Asante
Merci
Arigato
Grazie
Kiitos
Dankon
Maake
Salamat
Welalin
obrigada

MIAMI-DADE HIV/AIDS PARTNERSHIP

Prevention Committee Meeting

Featuring
Florida Department of Health - Miami-Dade County Prevention Mobilization Workgroup Presentations

- Black Treatment Advocates Network (BTAN) Miami-Dade Chapter
- Pre-Exposure Prophylaxis (PrEP) Workgroup
- Hispanic Initiative (Iniciativa Hispana)
- The Miami Collaborative MSM Workgroup
- Transgender Tenacity Power
- Youth Health

Thursday, October 28, 2021
10 AM - 12 PM

Miami-Dade County Main Library, 101 West Flagler St., Miami 33130 and via Zoom

Members are expected to attend in person.
Guest are encouraged to attend via Zoom.
Please RSVP to hiv-aidsinfo@behavioralscience.com