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Using Data to Improve Social Determinants of Health

WHITE PAPER

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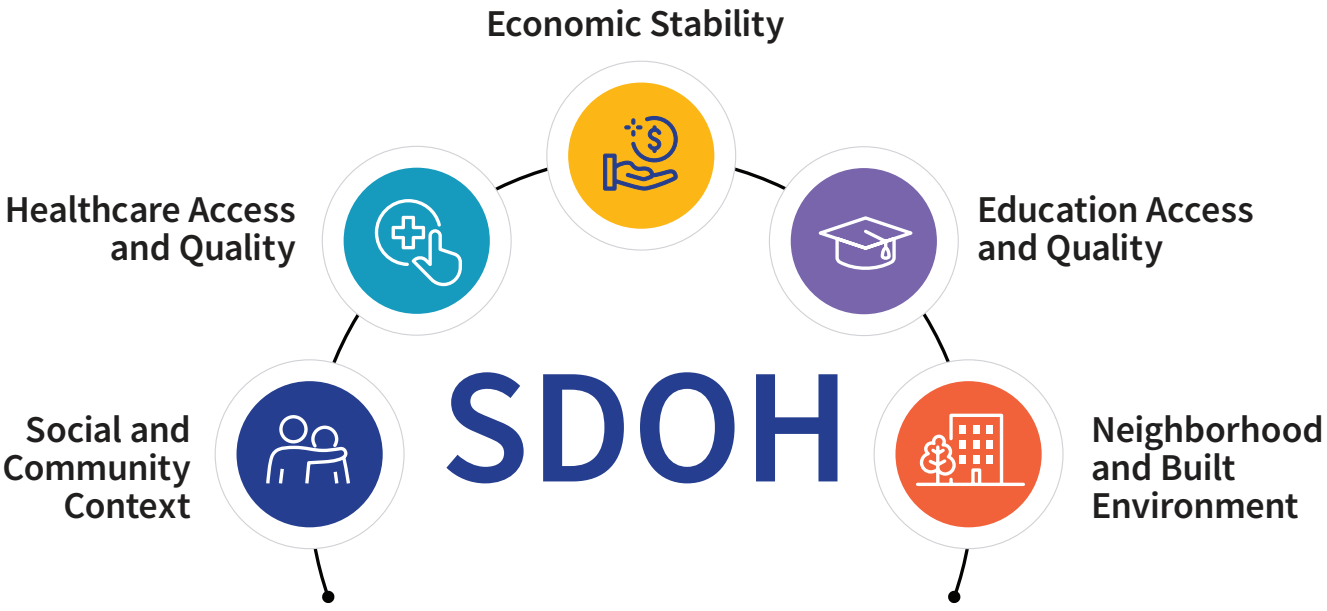


Improving social determinants of health (SDOH) and outcomes in general is an important part of the work we do every day. It might seem like a daunting task, but this white paper will give you a general understanding of what social determinants of health are, and how you can use data to improve outcomes for the people you and your agency work with every day.

What are Social Determinants of Health?

Social determinants of health are conditions, environments, and settings that impact not only health but also overall quality of life. People with disabilities in particular face a number of disparities and poorer outcomes compared to non-disabled peers due to an "increased risk of exposure to socio-economic disadvantage." People with disabilities are more likely to live in poverty, face social isolation, and have trouble finding affordable accessible housing. Ableism also impacts people with disabilities' health and outcomes.[1]

There are 5 domains of SDOH:[2]

- Economic Stability
- Education Access and Quality
- Healthcare Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Social determinants of health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

[1] Emerson et al., 2011, p. 146

[2] US Department of Health and Human Services

Case Study: Using Data to Improve Outcomes

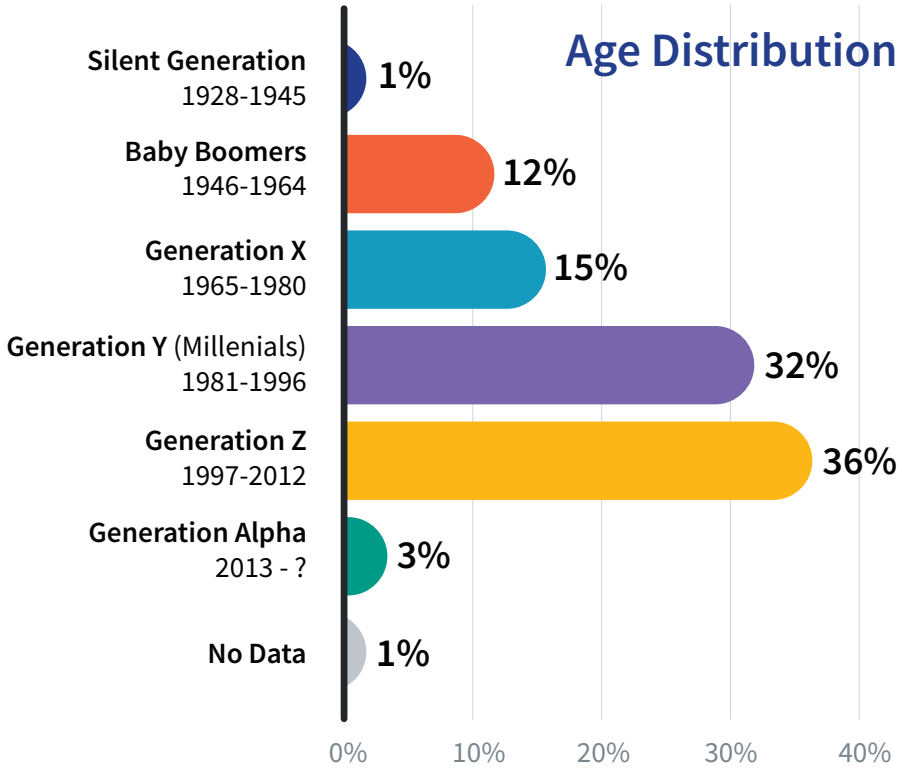
In order to display how you can use data to improve outcomes, let's focus on a case study from a current MediSked client agency. **The following data sources were used by a midwestern county Developmental Disability Office to start to understand their population health data:**

- MediSked Connect and Connect Exchange (EHR and Reporting/Analytics Engine)
- Individual Health Record
- State Mandated Assessment Data
- Demographic Data

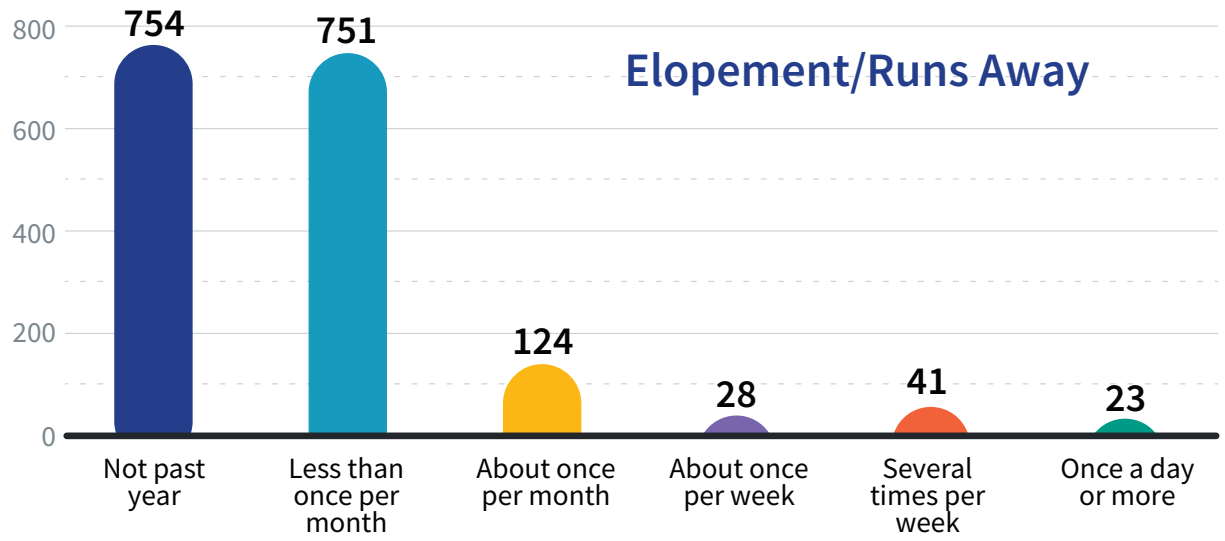
Assessment data will look at the most recent Assessment on file from October 1, 2021, through September 30, 2022. Data for this case study is powered by MediSked Connect Exchange – a Reporting, Analytics, and Integration Data Warehouse.

This client was interested in reviewing whether there was a correlation between the age/ generation of their population and the number of times the individuals were reported to have eloped (run away).

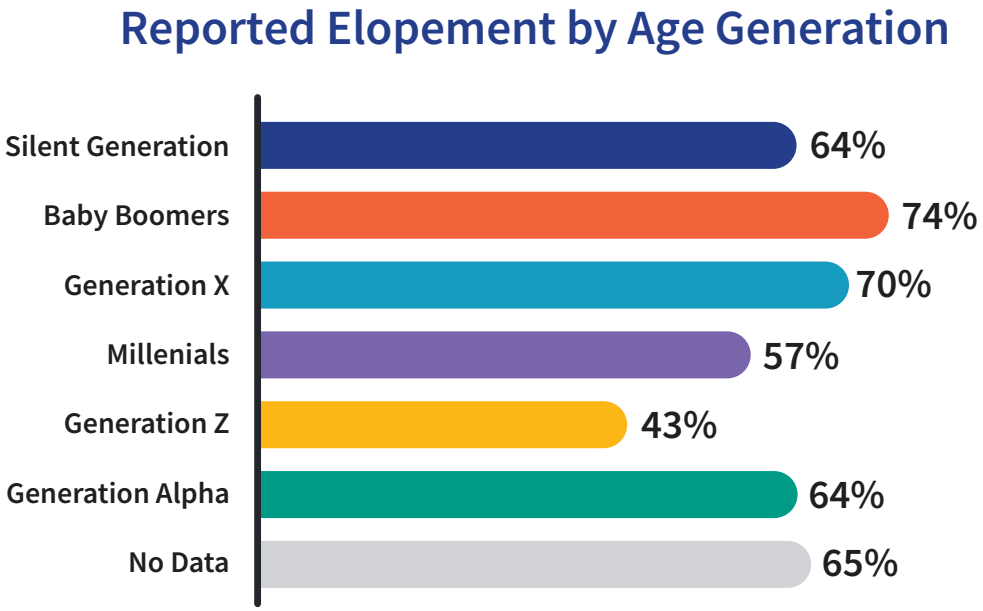
First, we looked at the age and generational distribution of their population.



Next, the agency decided they were interested in identifying the number of times someone has eloped, or ran away, over the past 12 months. This chart uses data from the state assessment tool, which is completed with the case manager, the individual receiving services, and their circle of support.



Once these two data elements are identified, the agency then had the tools to compare these data elements and see if any possible correlation between generation and the number of times a person has eloped or ran away in the past 12 years is identified. While they expected the oldest generations, as well as the youngest generations, to have a higher elopement rate, this comparison of actual data revealed a surprising result to them.



Note: It's important to reiterate that this is data from a self-reported assessment, and there may be cases where this question was not answered, resulting in the No Data category, which accounts for only 1% of the people who had assessments completed over the 12-month period.

Once the age/generation was compared to those who reported to have eloped/ran away at least once in the past 12 months, the agency was able to confirm that the youngest and oldest generations did in fact have high rates as expected. They were surprised, however, with the relatively high rate of Generation X elopements.

Their initial process assumed that the youngest and oldest generation may have an increased amount of elopement, which was taken into higher consideration when making recommendations to what type of residence and home staffing would be the most appropriate for these generations during service planning. Since they did not expect Generation X to have such a high rate of elopement, the focus on this was not as prevalent with that age group in their initial service planning process.

This agency was able to use real data from their system to update their internal service planning process to include additional screening for Generation X age people to help find the best residential setting for them and minimize the number of people in that generation who might be prone to elopement. The improvement in their process is now being tracked over the next 12 months to see if it has reduced the amount of overall elopement, and especially that within their Generation X population.

Ongoing Progress Monitoring

After trends are identified, and measures are taken to mitigate risk, it's time to track any changes from year to year in the data. Did the next 12 months of data show improvements? If yes, this is an indicator that modifications made to the Support Planning process are improving the SDOH outcomes of your population.

Was there no change or did the data trends move in a negative direction? **Yearly reassessment of the population data gives your agency the ability to continue to adjust the Service Plan process to continue moving towards improvements in the SDOH of their population.**

Regardless of which way your data goes year after year, being able to see improvement, or the need for more process adjustments, is critical to the work being done every day.

As Value Based Payments become more common, being able to identify and track progress in outcomes will be even more critical to ensure your agency is receiving the highest rate of reimbursement for services provided.

Yearly reassessment of the population data gives your agency the ability to continue to adjust the Service Plan process to continue moving towards improvements in the SDOH of their population.

Bringing it all together

This use case is just one element that this agency looked at when starting out on their journey to use their data to improve outcomes. **The only limits on the data you can use to improve outcomes are the limits on the data that you are collecting.** Using an Electronic Health Record, such as MediSked Connect, along with reporting an analytics tools like MediSked Connect Exchange, there are countless data elements and comparisons your agency can use to identify trends, make process adjustments, and track improvements year over year to improve the lives of the people with whom you work.

About the Author

Jeff Clair is a Project Management Institute certified Project Management Professional. With over 13 years in the Health Information Technology sector, Jeff has spent his past 5 years working with MediSked, a CaseWorthy Company, as a Solutions Consultant. He also has past experience working as a NY State licensed Life, Accident and Health Insurance Broker with a specialty in Employee Benefits Administration and Human Resources Administration.

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