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**From:** Akanbi, Olamide <Olamide.Akanbi@ProMedica.org>  
**Sent:** Friday, November 16, 2018 4:12 PM  
**To:** ASPE SES IMPACT Study (OS/ASPE)  
**Subject:** RE: ASPE Request for Information on Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Please find Paramount's responses to the ROI.

- How plans and providers serving Medicare beneficiaries identify beneficiaries with social risk factors
  - Our plan uses a claims based predictive modeling analytics database to assist with member stratification and identification.  
This database has a variety of tools to assess risk including; a clinical condition tool, a current health status classification tool, and an opportunity score tool which contains algorithms classifying members into a risk-stratified hierarchy based on individual scores from the following weighted components; Compliance, Cost, Lifestyle, Risk and Utilization. The Lifestyle component evaluates member specific socio-demographic health status, including housing/homelessness/zip code.
  - The assessments utilized within our plan's care management department, as well as the self-reported Health Risk Assessment, address a wide variety of social risk factors including but not limited to race/ethnicity, housing, food insecurity, safety, and personal health habits.
  
- Approaches plans and providers have used to address the needs of beneficiaries with social risk factors
  - Plan care managers share member centric care plans with primary care providers; requesting input and often collaborating with imbedded office care navigators to enhance member outreach and engagement.
  - Our plan uses a structured transition of care program for identifying and managing at risk members; using collaboration and coordinating care between various settings to assure barriers are identified and needs are addressed to reduce the likelihood of a readmission.
  - Directly connecting members with community resources; using 3-way calling, in person meetings, and/or frequent follow up to assure the member understands next steps and has the ability to make necessary connections.
  
- Evidence regarding the impact of these approaches on quality outcomes and the total cost of care
  - No update at this time
  
- Ways in which plans and providers disentangle beneficiaries' social and medical risks and address each
  - Performing accurate and thorough assessment of member in order to identify social risks
  - Prioritization of identified barriers/needs/risks with member input
  - Gap analysis related to needed/ordered services vs services completed; for example, following a hospitalization, were ordered medications, DME and home health services actually put into place for the member? If not, what prevented the completion? Cost, miscommunication, transportation, etc. Identification of this root cause may identify social risks that prevent the member from understanding or being able to address the medical care needed. This method can potentially lead to identifying causes for re-admissions, ED visits, lack of provider follow-up, and medication non-compliance.

- Often times, it is impractical to separate the social and medical risks; noting that someone who is concerned about their next meal or how they will afford to heat their home may not be capable of considering day to day management of a chronic condition, such as monitoring blood sugars or following a specific dietary restriction.

Thank you,

**Olamide O. Akanbi, JD, MPH**

Regulatory Coordinator

Paramount Health Care

1901 Indian Wood Circle

Maumee, Ohio 43537

419-887-2844

Fax: 419-887-2011

Email: [Olamide.Akanbi@promedica.org](mailto:Olamide.Akanbi@promedica.org)

[www.paramounthealthcare.com](http://www.paramounthealthcare.com)

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