Maxim Transition Assist

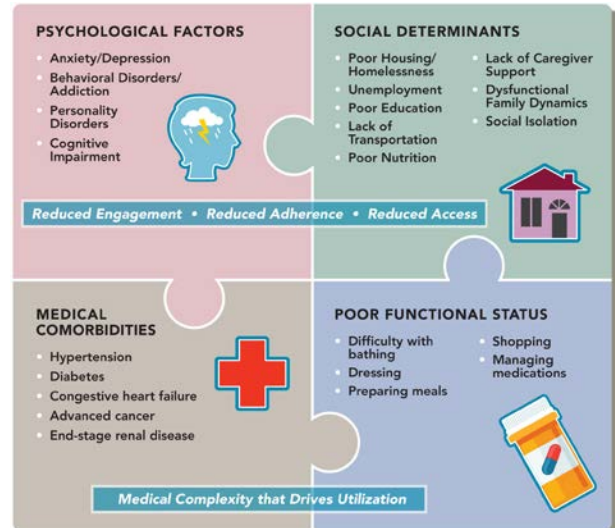
Reducing Avoidable Utilization Through Addressing Psychosocial Factors and Medical Complexities

Referral

Maxim's Community-Based Care Management program initiates when a high-risk patient is referred to the program via either directly from a hospital discharge, a payer such as a health plan or Medicaid agency, case management teams, primary care physicians, or other transitional care programs.

Assessment

A Maxim RN next conducts an in-home risk assessment based on four factors identified as driving costly healthcare utilization. The assessment evaluates patients psychological factors like addiction, depression, or behavioral health concerns; social determinants, for example lack of transportation, poor nutrition, or social isolation; medical comorbidities, including diabetes, high blood pressure, or congestive heart failure; and poor functional status, such as medication management and assistance with activities of daily living. Patients with these issues see reduced engagement, adherence to medical directions, and access to care, which, in turn, increase the risk of avoidable high-cost healthcare utilization when combined with medical complexities.



Care Plan

Maxim's clinical team then develops a personalized care plan for the patient to address aspects of these four areas that render a patient vulnerable for avoidable high-cost healthcare utilization. This care plan will be implemented with clinical oversight during the course of a defined time period ranging from 30 to 90 days.

CHW Engagement

The care plan is then executed by Maxim's team of Community Health Workers (CHWs), who complement rather than replace other providers a patient may have by partnering with these providers and building a relationship with the patient to ensure patient engagement and continuity of care across transitions. CHWs provide essential services, such as: driving patient engagement; reinforcing culturally appropriate health education; coordinating care; providing psychosocial support; and empowering communities through advocacy, capacity building, and barrier mitigation.

REFERRAL SOURCES

Four primary referral sources are:

1. Recent hospital discharges deemed high risk for readmission
2. Care management programs for high utilizers of acute health care services
3. Primary care physician referral of complex patients
4. Existing transitional care programs lacking a community-based care component

Health Status Update

At the end of the defined time period, an RN re-administers the assessment to determine whether the underlying factors leading to avoidable high-cost utilization are still present. If so, the patient is recommended for admission to Maxim Community Assist, which provides CHW services on an ongoing basis. If not, the patient is discharged from the program.

In February 2015, Maxim implemented this MTA program by partnering with the University of Maryland St. Joseph Medical Center to reduce preventable 30-day hospital readmissions. Through focusing on high-risk patient populations, MTA has to-date provided 1,800+ NP assessments, 1,100+ RN assessments and 11,800+ hours of home-based CHW support, reducing readmissions by over 64% in its first eighteen months.