



MAXIM HEALTHCARE SERVICES, INC.

IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

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OVERALL QUESTION

1. How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

From Maxim's perspective as an engaged national healthcare partner and provider, we have seen a consistent trend in State health plans and local providers increasingly supporting the integration of Social Determinants of Health (SDoH) data into their strategic program development to support Medicare beneficiaries.

Rather than developing programs that are reactive to the health disparities that arise from the presence of various SDoH and barriers to adherence, Maxim strives to work with various providers and health plans to develop plans that will proactively address the underlying causes of Social Risk Factors. Maxim serves as a healthcare partner and provider of choice to more than 8,000 clients nationwide, including state Managed Care Organizations (MCOs), Care Transformation Organizations (CTOs), Accountable Care Organizations (ACOs), local and federal government agencies and departments, hospitals, correctional facilities, and commercial health plans. We leverage our robust caregiver network, our national presence, and our 30 years of experience in developing comprehensive, community-based programs that address the complex healthcare challenges individuals face on a daily basis.

Maxim believes that to affect lasting change, programs must first address the social barriers to adherence to overcome underlying health disparities, and ultimately improve their health outcomes. Maxim's customized community-based care service offering serves as the natural extension of our core service capability: providing a clinical and non-clinical support network for patients across the continuum of care.

DELIVERY OF SERVICES

1. Are social risk data being used to target services or provide outreach? If so, how? How are beneficiaries with social risk factors identified?

Yes. In addition to data available from our partners about the socio-economic and health status of the population being supported, Maxim utilizes our proprietary Health Risk Assessment to stratify participants based on their individualized health risk status.

To identify social risk factors, Maxim's proprietary assessment is used to quickly and efficiently assess a patient and their family's status in their home, allow Maxim to assess them in an environment that is both comfortable and a realistic look at their day-to-day lives. This assessment identifies any existing deficits, barriers, or gaps in care.

Our assessment is rooted in the belief that total health and wellbeing hinges on four specific domains: **Medical, Functional, Psychological, and Social**. An example of a clinical assessment for a specific program might be as follows:

- ◆ **Physical/Functional Assessment**
- ◆ **Medication Reconciliation**
- ◆ **Environmental Assessment**
- ◆ **Behavioral/Social Needs Assessment**

Based on the results of our health risk assessments (HRAs) conducted in the home, Maxim develops a personalized Comprehensive Care Plan for each person, tailored to address the participant's unique social risk factors.

2. Are there especially promising strategies for improving care for patients with social risk?

Yes. Maxim has seen significant improvement in both individuals and a total participant population when Maxim is able to fully implement all aspects of our Community-Based Care Management strategies, including but not limited to:

- ◆ **Comprehensive Care Plan:** The results of Maxim's intake assessment drive the development of a customized comprehensive care plan that meets the patient where they currently are, and sets tangible goals based on the patient's long-term needs and goals. Maxim can work collaboratively with customer-specific Case Manager(s) to ensure that the Care Plans Maxim is recommending support existing Case Management treatment plans or health initiatives.
- ◆ A team-based approach to coordination and program management to ensure support across the continuum of care
- ◆ Forging relationships with non-traditional community stakeholders who are familiar with the geographic and socio-economic landscape of a particular region/population. This strategy allows Maxim's programs to address the total health of a population through expanded relationships with providers and practices, and allows entire communities to realize and actualize their health and wellbeing goals.

- ◆ Data integration with existing member information, HRA results, and other data sources to identify and assess health risks, and serve as a predictive indicator for future population trends.
- ◆ **Hospital to Home Programs:** Maxim’s Hospital to Home Programs are intended to support our customers’ more vulnerable populations from the point of discharge from the hospital and their return to their homes.
 - **Transitional Programs:** Members who are at elevated risk for readmission to acute care facilities are linked to the program prior to their discharge. Our Community Health Workers (CHWs) provide assistance in transitioning the member to a post-acute setting. Maxim’s goal with these members is to reduce the likelihood of readmission.
 - **Transitional Care Coordination:** Provides transitional care services to bridge the gap between the hospital and home by providing continuity of care across the transition. Maxim’s Transitional Care Coordinators are nurses whose role is to establish a relationship with the patient in the hospital, identify needs for a comfortable transition home, and develop a custom transitional care plan for post-hospital services that address these factors while working directly with a local Maxim clinical team to support the transition.

3. How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?

While there are fixed costs to some of our services, such as specific vaccination costs, or a per-assessment fee, much of our pricing is subjective depending on the size and scope of the proposed program, the size of the population being supported, and other program-specific components that may impact pricing is structured.

In regards to return on investment, to illustrate the potential impact of our programs, we have included a chart that shows the results of a two-year case study for one of Maxim’s Community-Based Care Management programs. It illustrates that the program began with a 25 percent readmission rate for high-risk patients, which was reduced to an 8-12 percent readmission rate over time.



"We began working with the University of Maryland on a program that is very focused on the social determinants side of non-clinical barriers to adherence. We started focusing on readmissions, but quickly realized that for a lot of patients, readmissions are only a symptom of these underlying problems. [Patients are] suffering from socioeconomic challenges that are preventing them from following the care plan you've outlined, so if you can address those, the utilization comes down as a byproduct."

-Andy Friedell, Senior Vice President of Strategic Solutions, Maxim Healthcare

4. What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?

Maxim's Community Health Workers are the core of our Community-Based Care Management programs. Our CHWs are the most critical factor in assessing and supporting participants, as well as linking them to existing community resources to address underlying social risk factors that are negatively impacting their health status or have become a barrier to adhering to their treatment plan. The goal of utilizing CHWs in a particular community is to have the CHW function as a connector between healthcare consumers and existing resources and support systems to promote health among communities that experience barriers to accessible healthcare, as well as elevated risks for specific health issues.

The primary role of a CHW is to develop a relationship with patients and their families based on mutual trust and founded in respect, thus identifying and linking them to the services they need to achieve total wellbeing.

CHWs specialize in care coordination with community resources, including but not limited to medical, behavioral health, rehabilitation, or social services. By engaging patients in a relationship based on mutual trust and respect, and linking them to existing resources in the community, CHWs empower patients and entire communities to manage their health conditions while reducing dependence on unnecessary and high-cost hospital services.

5. What lessons have been learned about providing care for patients with social risk factors?

Maxim believes that assessing social risk factors concurrently with medical risk factors leads to greater success in developing and delivering care that has long-lasting results, as well as improving the health outcomes of a total population. While of critical importance to the success of community-based care programs, assessing and providing care for patients with social risk factors presents a number of interesting challenges.

We have learned that cooperation and coordination with providers is essential to better integrated care teams, which leads to reductions in gaps in care. We have also learned that supporting these populations requires creative approaches to providing care. To generate a true medical return on investment for patients with significant social risk challenges, Maxim must invest time, energy, and resources into activities that may fall outside of the traditional scope of the healthcare system.

Additionally, these programs require relationships that are less transactional and more continuous in nature, which is why Maxim emphasizes the importance of our Community Health Worker network. Maxim has also learned that program success requires big picture thinking to tackle the concept that you cannot address the issue of high-cost healthcare utilization without first addressing underlying issues that may not be immediately identifiable as a healthcare challenge, such as social isolation, lack of transportation, environmental, or logistical issues.

6. What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?

While barriers to tailoring services will vary depending on the cultural and geopolitical landscape of various states and communities, the most general and difficult barrier to overcome is a lack of fiscal and literal resources available to address barriers to adherence. A lack of resources can manifest in different ways – from insufficient transportation and housing to limitations in childcare and unemployment.

Maxim understands that no two programs will be exactly alike, and as such we approach the strategic development of each program in close collaboration with our customers to ensure that we have the framework in place to support the population's unique needs and anticipate the common barriers that may be associated with supporting that specific population. This allows us to preemptively determine care plans that can link participants to a specific community resource.

For example, for a high-risk Medicare population, common barriers to adherence and the community-based resources that could be used to overcome those barriers might be as follows:

Barriers to Adherence	Community-Based Resources
<ul style="list-style-type: none"> ◆ Social Isolation 	<ul style="list-style-type: none"> ◆ Support Groups ◆ Mental Health Agencies ◆ Community Action Councils
<ul style="list-style-type: none"> ◆ Lack of Transportation 	<ul style="list-style-type: none"> ◆ State-Sponsored Public Transportation/Ride-Sharing ◆ Expanded Partnerships with Lyft/Uber
<ul style="list-style-type: none"> ◆ Financial Instability 	<ul style="list-style-type: none"> ◆ Food Banks ◆ Care Coordination ◆ Rental/Utilities Assistance ◆ Transitional Housing

7. For patients with social risk factors, how does a patient’s disability, functional status, or frailty affect the provision of services?

Maxim’s Health Risk Assessment does not only measure social risk factors, but also takes into account any physical or medical comorbidities that may influence the level of care that a participant would receive. Maxim has been one of the nation’s leading providers of in-home healthcare services for 30 years, which is what makes our Community-Based Care Management services a natural extension of our core service offering. Our programs hinge on the belief that the most effective way to provide treatment is to treat the whole person – this includes any physical disabilities or functional limitations – and create a care plan that addresses *all* measures of health.

The results of the intake assessment will drive the development of a customized comprehensive care plan that meets the patient where they currently are and sets tangible goals based on the patient’s long-term needs and goals. Once these assessments are completed and the relevant barriers to care identified, Maxim’s EMR system will aide in developing a Comprehensive Care Plan unique to the individual and their specific barriers and challenges.

The plan then outlines barriers/issues, goals, and specific encounters for the team to implement or execute over the course of that phase of the client’s time with Maxim. Team members then use the care plan to help clients achieve mutually agreed upon goals. The Care Plan helps guide CHWS and provides a place to document progress toward goals. A participant’s functional status and any physical disabilities will be factored into the level of care recommended.

DATA

1. Which social risk factor are most important to capture?

Maxim considers transportation, nutrition, housing, finances, and social isolation to be the most important social risk factors to capture. These factors have the most measurable impact on improving health outcomes and access to care, as well as generating meaningful, long-term impact on the healthcare costs by reducing potentially-avoidable healthcare utilization.

- ◆ **Transportation:** A lack of reliable transportation greatly limits a participant’s ability to access primary care and specialty appointments on a regular schedule. A lack of transportation also limits a participant’s ability to obtain their medications from pharmacies or regularly visit a grocery store, resulting in missed doses and non-adherence to treatment plans, as well as poor dietary habits.
- ◆ **Nutrition:** Improper nutrition is a major factor in negatively impacting participant health outcomes. Individuals who are not properly educated on the proper nutrition for themselves, or who are unable to access proper nutrition, either due to financial limitations or transportation issues, can experience complications to their existing health issues, resulting in higher long-term and immediate healthcare costs.
- ◆ **Housing:** Housing – both chronic or occasional homelessness, as well as housing insecurity - are critical risk factors to capture as they dramatically impact a participant’s ability to adhere to treatment and receive services. Housing insecurity occurs when an individual spends a disproportionate share of their monthly income on housing (over 50%), leaving fewer resources to spend on

nutrition, medications, transportations, or medical costs for copays and insurance premiums. It is also important to capture environmental factors in the home, such as mold, dust, pollen, or pollution, all of which can exacerbate respiratory conditions and other factors. Community and public safety issues can also have direct health impacts, as well as implications for behavioral and psychological health. There is growing research that indicates that an individual's ZIP code has stronger statistical correlation to health outcomes than an individual's genetic profile.

- ◆ **Financial Stability:** An individual's financial stability has a number of implications for a person's health. Access to affordable insurance affects a person's ability to and likelihood of obtaining low-cost preventative healthcare services. This can lead to reduced overutilization of Emergency Departments for treatment of manageable conditions. This also impacts a patient's ability to afford medications and food, while having a dramatic impact on psychological issues such as anxiety and depression, which can negatively impact health outcomes. Awareness of and connection to social and community resources that a patient is eligible for (free or reduced cost) can improve engagement with the healthcare system but also connection to other social resources that have long-term impacts on health status.
- ◆ **Social Isolation:** The absence of family and friends in the home or within a reasonable distance can have a number of ramifications. First, it affects the patient directly by resulting in a loss of hope and increased risk for depression and anxiety. Lacking a support system can impact a person's ability and willingness to engage with the healthcare system. Social Isolation also exacerbates the impact of barriers resulting from cultural or language differences or educational issues like literacy or non-familiarity with technology. Being connected to others can increase these social network connections that serve as a safety net between the patient and the Emergency Department.

While the overall goal is community vitality, it is important to remain focused on those risk factors that have the most concrete and immediate impact on health outcomes without being distracted by any and all social factors.

2. Do you routinely and systematically collect data about social risk?

Yes. Our proprietary Health Risk Assessment is utilized in our Community-Based Care Programs to provide an accurate snapshot of each participant's risk status at that moment in time, and is used to develop the corresponding Care Plan.

3. Who collects the data? When is it collected?

Upon referral to our program a nurse practitioner visits a patient's home and performs the initial health assessment. This creates an opportunity for the patient and their family to discuss with a practitioner the health risks and improvement measures that can be taken to alleviate some of the risks.

4. Is data collected once or multiple times for a beneficiary?

Data is collected at multiple times throughout the program, though the frequency of data collection varies depending upon specific program goals, and can be collected on a weekly, quarterly, monthly, or annual basis per the customer's wishes. Typically, Maxim conducts an Initial Intake Assessment which determines the parameters of the Care Plan. Within the Care Plan, specific goals are set for the participant – if the participant is unable to meet the goals and milestones set in the Care Plan, Maxim will conduct a periodic reassessment and adjust the Care Plan.

5. Is data collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)?

Yes. Maxim's programs collect data across the total population we're supporting with a specific program.

6. What are the burdens of this data collection on plans, providers, and beneficiaries?

Maxim has devoted significant resources to developing an interoperable technology and data systems to ensure our ability to capture all relevant participant data and transmit that data in a timely, accurate fashion. Maxim's programs are structure in a way that the vast majority of the data collection falls primarily on Maxim, and as a result the burden on the plan, provider, and beneficiaries is minimal.

To conduct assessments, Maxim utilizes our **Electronic Medical Records (EMR) System**. This scalable and tablet-friendly system can be used in an online or offline setting and allows caregivers to conduct assessments, develop care plans, and document interventions at the point of care.

Maxim has established data integration formats and processes with over 500 health plans, broker/consultants, data warehouses and wellness companies. We integrate results into electronic health records (EHRs), personal health records (PHRs) and other online health assessments using a variety of secure data formats. We have employed various technologies to link information with our partners.

Sharing solutions has been as simple as a flat file dump transferred over a secured connection such as SFTP, email with encrypted contents via PGP, or more in-depth processes such as SSO (Single Sign On) via the SAML protocol or Web Services via SOAP or REST for reporting and tracking.

7. Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?

Yes. Data points on social risk factors are difficult to standardize because, in many cases, these factors are not yet incorporated into EHRs, due to resources and providers being community-based and not yet embedded in the healthcare system. Incorporating non-medical or non-healthcare providers, including entities that provide housing assistance services or nutritional support, like Meals on Wheels, streamlines the application processes for resources and results in benefits being better coordinated with care plans, all of which drives the long-term goal of standardization.

8. What are barriers to collecting data about social risk? How can these barriers be overcome?

Collecting data directly from the participant about their social risk status can provide unique and otherwise unreported insights into patient experiences, allowing our team to better construct a Care Plan that addresses all factors of their health and wellbeing.

However, due to the sensitive manner of this form of data collection, there can be some limitations. The most common barrier to collecting data about social risk directly from a participant is a lack of mutual trust between the participant and the caregiver conducting the risk assessment, which may lead to the reporting of incomplete data from the patients from whom data is most important to collect. These patients are often the most difficult to locate or engage or more resistant to engaging with the healthcare system. It is because of this specific barrier that Maxim utilizes our Community Health Worker (CHW) workforce. By nature of their roles, CHWs are members of the same community as the participant they are supporting, and oftentimes they may have personal experience with many of the same social risk factors that the participant may be experiencing.

Another common barrier to collecting data are the limitations of a participant's health literacy levels, which may mean the participant is unable to fully articulate their risk status. The success of a Community-Based Care Coordination program hinges on the ability to engage participants at any level, regardless of current risk status or health literacy levels.

To ensure that participants who may be resistant to change are receiving support that provides them with realistic goals and tactics for achieving those goals, all Maxim CHWs are trained in conducting **Motivational Interviewing** as well as tools to increase emotional intelligence.

Motivational Interviewing is an evidenced-based approach to help patients suffering from comorbidities drive positive behavioral changes. Motivational interviewing replaces the more traditional method of "advice giving" with "reflective listening". While a CHW or provider may give sound medical advice, the patient, often concurrently, resists the advice. The motivational interviewing process reframes the patient-provider interaction through goal-oriented, patient-focused counseling that challenges patients to address the underlying causes for their issues. The five principles of motivational interviewing are as follows:

- ◆ Express and show empathy
- ◆ Support and develop discrepancy
- ◆ Address resistance and identify root cause
- ◆ Support self-efficacy
- ◆ Develop skills for autonomy

9. What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

Maxim sees opportunities to improve the quality of data being collected during in the following ways:

- ◆ Combining the technology of our tablet-based assessments and Electronic Health Records (EHRs) with our caregiver presence in the home. This allows for a more accurate risk-stratification process, and will provide a more complete picture of the participant's total health and wellbeing status.

- ◆ The more accurate the data collected, the more comprehensive and customized our care plans will be, resulting in more targeted interventions, more effectively allocated caregiver resources, and improvements in quality of care.
- ◆ The incorporation of social resources into technology platforms will streamline applications for relevant social and community resources and benefits.
- ◆ Automatic applications based on eligibility criteria, or even creating a centralized hub or application for various benefits would greatly streamline the application process, and would result in better patient health outcomes.

To support these principles, Maxim recently formed a partnership with Leidos Health. With Leidos support, Maxim intends to leverage available technological resources to engage with our nation-wide network of caregivers in a more strategic manner.