MAXIM HEALTHCARE SERVICES

A Partner for Pediatric Care in the Home

The Elements of a Maxim Partnership

OUR CLINICAL ADVANTAGE

We take pride in having built a patient-centered clinical model that is uniquely designed to support the complex needs of a pediatric population. This model includes comprehensive caregiver training, strong competency assessments, and quality data measurement and continuous improvement.

Coordinated Home Healthcare Services

We provide patients the ability to maintain their independent lifestyle while remaining at home. Services provided through our home healthcare offices and coordinated through committed clinical teams may include any combination of the following services:

- Skilled medical care
- Complex, extended hourly care nursing (trachs, vents)
- Intermittent care (infusions, wound care)
- Therapy services
- Respite care
- Companion care
- Care for people with disabilities
- Personal care
- Activities of daily living (ADLs) assistance
- Behavioral services
- Other household services

Training

Training is at the heart of our success. We have developed comprehensive and innovative training programs designed to ensure clinical competency for nurses caring for patients needing skilled care. Our training also offers options for nurses to learn new clinical skills.

For example, our Novice Nurse Program provides new nurses (RN, LPN/LVN) with valuable mentorship and home healthcare experience. Additionally, our adult to pediatric crossover programs prepare adult care nurses to transition to caring for pediatric patients.

About Us

We are a leading national provider of in-home nursing care for medically fragile and technology-dependent pediatric patients. We collaborate with children's hospitals to enhance the continuum of care for our patients from acute to post-acute settings. These partnerships are built around:

- Strong clinical advantages which are integrated into our model
- Innovative training programs for our caregiver teams
- A willingness to dedicate resources for our patients and at our local offices
- An ability to share data measuring patient outcomes
- Community-based care interventions aimed at helping reduce avoidable readmissions and complications

We integrate all of these clinical interventions, trainings, transitional support, and care coordination activities into home and community-based services that engage the patient, family, caregivers and physicians.

Contact us today for more information!

maxim® healthcare services

RESOURCE COMMITMENTS

Transitional Care Coordination

The transition period between acute care and post-acute care has been shown to be a time fraught with medical errors and misunderstanding on the part of the patient/family and the referring facility. Our goal in developing the transitional care coordinator (TCC) program is to improve patient safety during this period by enhancing communication and coordinating services among family, the referring facility and Maxim.

The Maxim transitional care coordinator is an RN whose primary role is to improve the care of our patients by providing enhanced communication and care coordination with referring facilities. Our TCCs serve as a bridge between hospital care and our home healthcare services by building relationships with physicians, nurses, case managers, social workers, other clinical personnel, and our patient's family to make the transition period as safe and efficient as possible.

Discharge Coordination

Discharge coordination ensures that patients leaving a healthcare facility can fully recover at home with the support and resources they need. Through care coordination and organized, RN-led case conferences, we work alongside case managers, discharge planners, and physicians to assist in developing the most appropriate plan for our patient post discharge. This process can include: assisting in determining resources for special medical equipment, assisting in the arrangement of necessary appointments, working closely with insurance companies, keeping accurate care coordination records, and assisting in evaluating our patient's community and home environment needs.

Dedicated Recruitment

As a nationwide employer of more than 65,000 healthcare professionals, we recognize the importance of a strong caregiver workforce. In order to identify and retain this workforce, we employ 800 healthcare recruiters across our offices and dedicated recruitment hubs throughout the country. The dedication of recruitment and other office personnel in identifying and supporting our caregivers is paramount to our successful delivery of effective home healthcare.

QUALITY DATA REPORTING

We have developed systems for tracking our outcomes data, and are using that data to improve patient care. Very little data is available that measures private duty nursing (PDN) care, particularly the care provided to pediatric patients. We track hospitalizations, re-hospitalizations, infections, unanticipated emergency department visits, falls, medication errors and other clinical points. By tracking and trending these occurrences locally and regionally, we are able to implement additional caregiver training and tools to improve care.

A partnership with Maxim allows your patients to gain independence in the comfort of their own home. The combination of our local footprint, resource commitment, and robust clinical infrastructure will ensure your patients have the choice to select a home healthcare agency with expertly-matched caregivers.

Community-Based Care Management (CBCM)

We partner with hospitals to help reduce avoidable utilization among high-risk patients post-discharge. Our approach to this problem is built around a model that is heavily-weighted toward the social and behavioral health challenges that frequently prevent some patients from adhering to their clinical care plans. We implemented a program in partnership with the University of Maryland St. Joseph Medical Center, near Baltimore, to reduce unplanned 30-day hospital readmissions. Focusing on high-risk patient populations, we helped reduce readmissions by nearly 66% in our first two years. Our CBCM program model resulted in over $1.7 million in avoidable hospital variable costs and nearly $4.4 million in avoidable readmission costs during that period.

Compliance Results and Recognition

We have established a comprehensive and rigorous compliance and ethics program that has received five Compliance Best Practices Awards from the Health Ethics Trust (HET), a division of the Council of Ethical Organizations. Every area of our comprehensive compliance and ethics program has now been recognized as a best practice for the healthcare industry.

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