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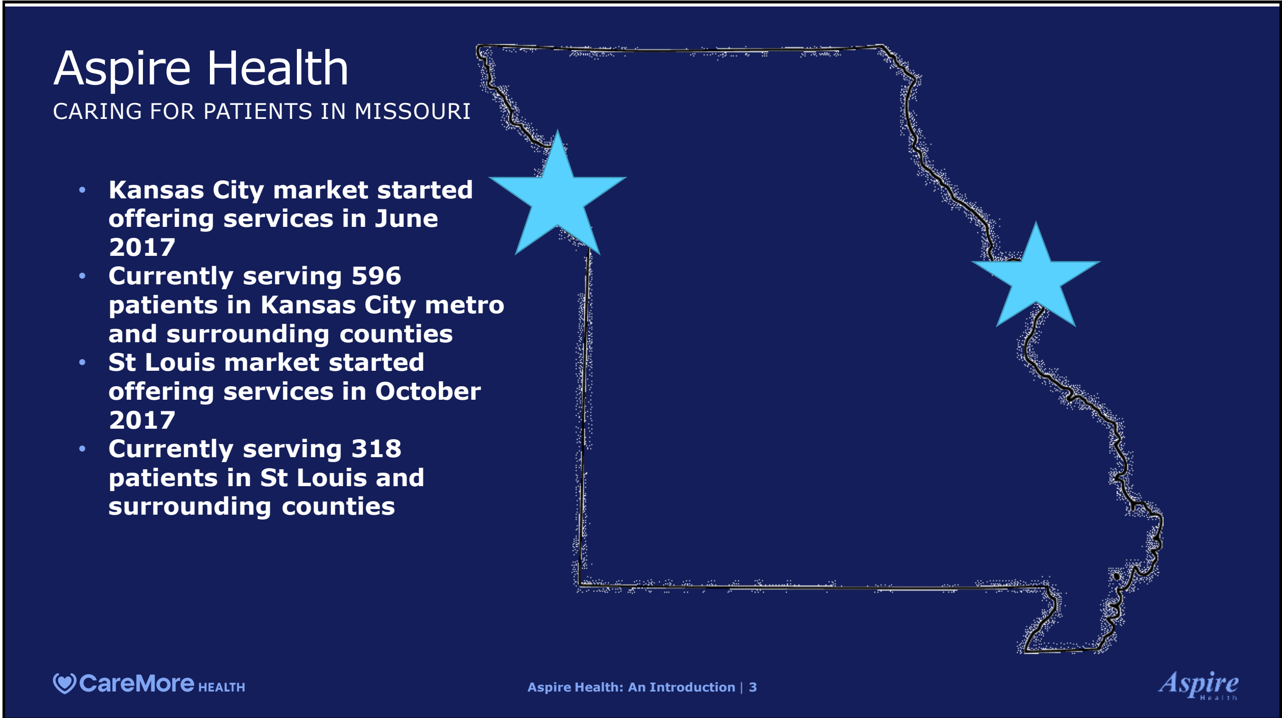
Our partners in improving care delivery

2



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Executive Summary

1 | What problem does it solve? ❯
- Provides patient-centered and coordinated interdisciplinary care to support patients with advanced potentially life-limiting disease and their families. Prevents fragmentation of care and ensures care is aligned with patient's goals.

2 | How do we succeed? ❯
- Focus on patient/proxy understanding of current disease state and expected progression, anticipate and treat symptoms, and establish advance care plans that reflect patient's health care goals to minimize unnecessary hospitalizations and encourage the appropriate level of care.

3 | How do we deliver care? ❯
- Conduct in-person visits in the patient's home, encouraging engagement of key decision-makers.

4 | **How are we doing?** ❯
- Strong performance on key clinical indicators and highly productive. Working to increase enrollment to meet desired performance metrics.

5 | Adapting during COVID-19 pandemic ❯

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Clinical outcomes that **matter.**

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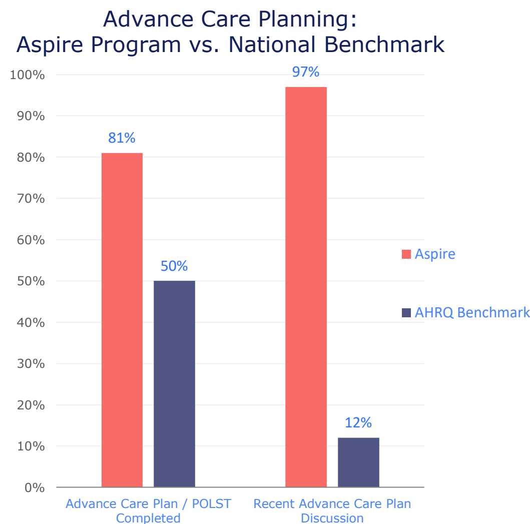
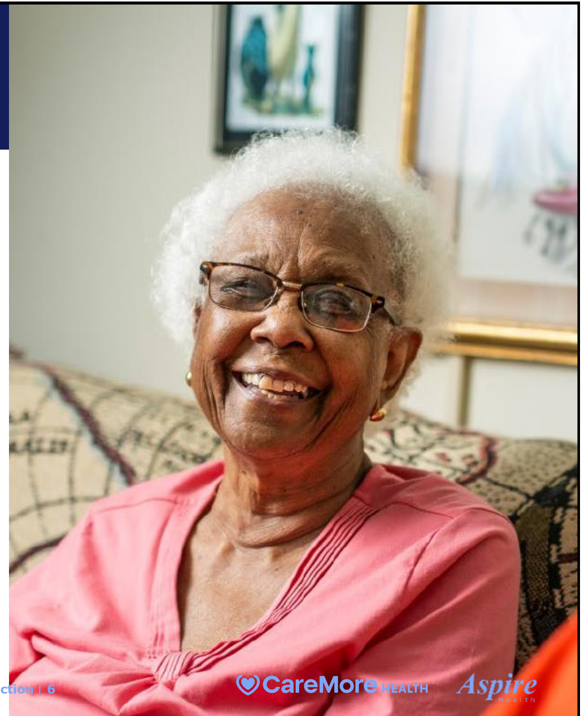
Palliative Care

ADVANCE CARE PLANNING





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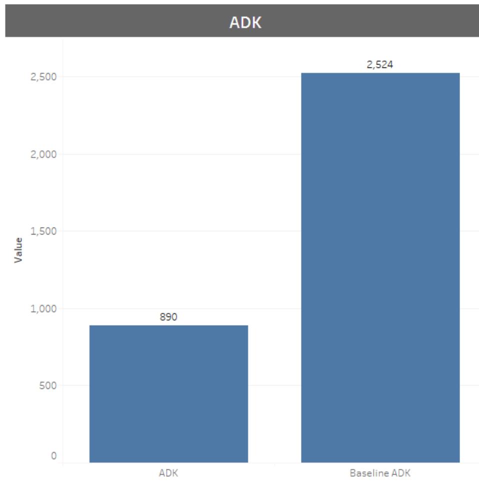
Palliative care
HOSPITALIZATIONS



Hospitalizations (admits/k):
Aspire Program vs. Non-Aspire Program

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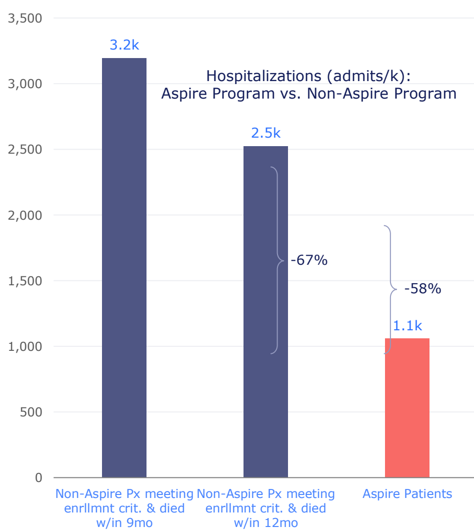
Palliative care
HOSPITALIZATIONS



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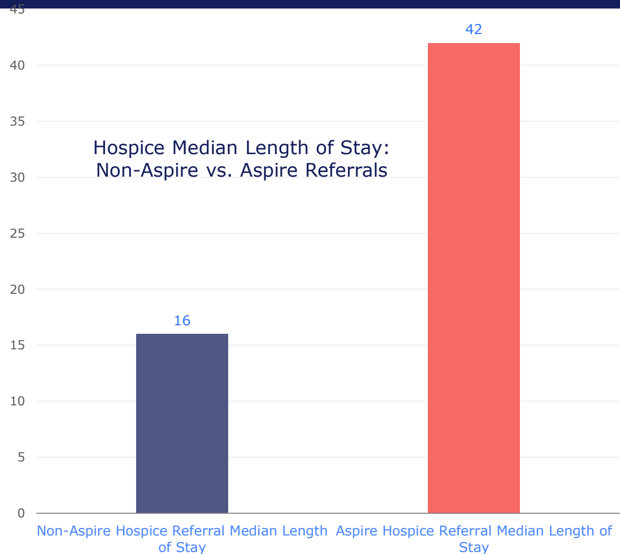
Palliative care

HOSPICE UTILIZATION



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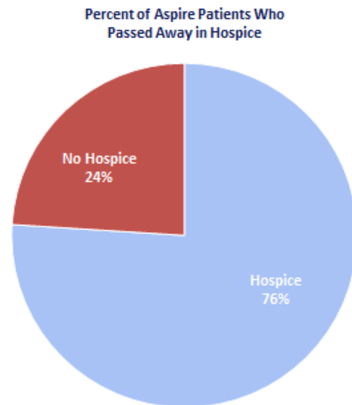
Palliative Care

HOSPICE UTILIZATION



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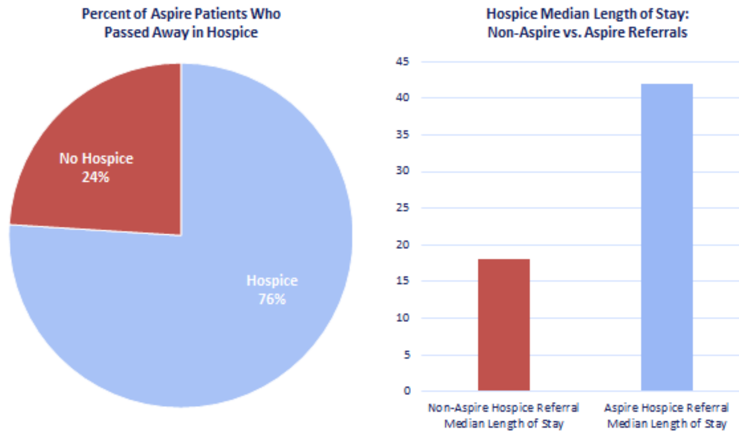
2020 Outlook | Quality of Care



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Home-Based Program Outcomes Clinical Quality

Measure Category	Measure	Outcome
Medication Reconciliation	% of program participants that receive in-person medication reconciliation on intake and at each clinical visit	100%
Pain Assessment	% of program participants assessed for pain using a standardized pain assessment tool at the first visit	100%
Pain Management	% of program participants who report pain relief on a negotiated pain scale	82%
Symptom Assessment	% of program participants assessed for troubling symptoms using a standardized symptom assessment tool at the first visit	100%
Functional Assessment	% of program participants assessed for functional status using a standardized functional assessment tool at the first visit	100%
Fall Assessment	% of program participants that have a documented fall risk assessment	100%
Home Safety	% of program participants that receive a home safety assessment during the first home visit	100%
Mental Health & Substance Abuse Screen	% of program participants assessed for mental health status and substance abuse using a standardized assessment tool	100%

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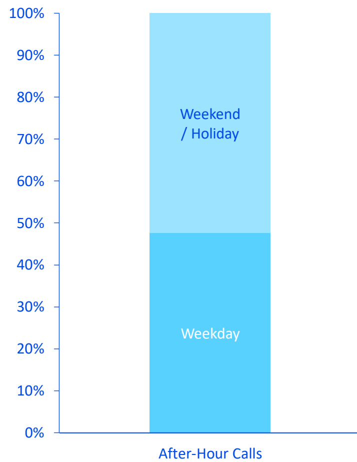
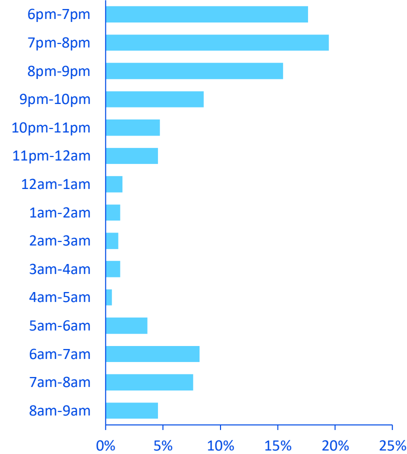
Home-Based Program Outcomes After-Hours Calls





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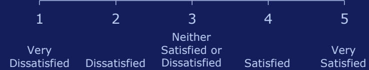
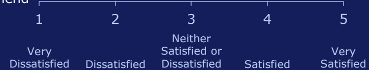
What our Patients Say

WHAT REALLY MATTERS





Respondent completing survey: 56% patient/44% family or caregiver

Your care has kept me out of the hospital.

My fear factor drops way down.

Your interventions saved me from ending up in a nursing home.

It has relieved a lot of anxiety.

It is wonderful to have home visits.

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Executive Summary

1	What problem does it solve?	Provides patient-centered and coordinated interdisciplinary care to support patients with advanced potentially life-limiting disease and their families. Prevents fragmentation of care and ensures care is aligned with patient's goals.
2	How do we succeed?	Focus on patient/proxy understanding of current disease state and expected progression, anticipate and treat symptoms, and establish advance care plans that reflect patient's health care goals to minimize unnecessary hospitalizations and encourage the appropriate level of care.
3	How do we deliver care?	Conduct in-person visits in the patient's home, encouraging engagement of key decision-makers.
4	How are we doing?	Strong performance on key clinical indicators and highly productive. Working to increase enrollment to meet desired performance metrics.
5	**Adapting during COVID-19 pandemic**	Implementing virtual visits. Continuing with home visit and support to patients and PCPs.

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Palliative Care Model 2021

Leveraging Virtual Visits

Incorporating Different Types of Roles

Optimizing Care Design and Operations

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A Patient's Journey
Transition to Hospice

Background

- Male, late 70s, history of vascular dementia & COPD.
- Admitted to Aspire services in 2017 after SNF
- Lives with supportive wife who values being his sole caregiver
- More functional declines noted over the last year
- Patient's wife hesitant to accept home hospice services

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Identifying Solutions
Transition to Hospice

Interventions

- Care team collaborated to support patient
- Social Worker reinforced how goals aligned with home hospice
- CMRN initiated weekly calls to patient's wife and provided education
- E-kits of antibiotics were kept in home to avoid ER visits/hospitalizations
- Patient's wife was given APP's direct phone number

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Best Practice in "Leveraging Telehealth To Support Aging Americans" in Coalition to Transform Advanced Care-AHIP Collaboration report LINK

Innovative Care Model for Advanced Illness Management LINK

Aspire Highlighted as Leading Example of Innovative, Home-Based Care LINK

A New Model of Community Care LINK

Aspire Health Ranked 5th Fastest Growing Private Company in Tennessee. LINK

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