CareFirst Medicare Advantage

Frequently Asked Questions for Providers

1. **Who is Aspire?**
   Aspire, in simple terms, is a community-based palliative care program. Aspire's service is focused on driving a range of critical outcomes including, but not limited to: patient and family satisfaction; improved quality of life; disease and symptom management; completion of advance care planning; a reduction in hospitalizations and, when clinically appropriate, effective and timely transitions to hospice care. Their main focus is treating patients who are facing advanced illness, likely in the last year or so of life. Their main enrollment question is: "would you be surprised if this patient passed away in the next 12 months?"

2. **What is Aspire's approach to care?**
   Care is provided by our interdisciplinary team of advanced practice providers (APPs), physicians, social workers and nurses. Additionally, we have a 24/7 on-call line answered by local market physicians and APPs to assess, educate, reassure and support patients with new onset symptoms or other urgent needs. Patients are visited routinely, about 1 to 2 times per month on average, and more frequently as needed. They have capability for urgent visits and, in the event a patient is hospitalized, they schedule transition of care visits to offer wraparound support during the vulnerable post-discharge period.

3. **How does Aspire identify and engage patients?**
   The clinical portion of our intervention is bolstered by data analytics that facilitate identification of a target patient population likely to benefit from their program to ensure they are supporting the right patients at the right time. They leverage a proprietary algorithm that has been refined through their seven years in practice and care of over 100,000 patients—their algorithm runs on claims (medical and pharmacy) and eligibility data provided securely by our health plan partners. Once patients are identified & approved for outreach, they send an introductory letter and then outreach telephonically to offer the service. From there, they provide care through a co-management approach with other members of a patient's care team, including primary care physicians and specialists. They also welcome direct referrals from providers in the community, as well as from their health plan partners' case managers and utilization managers.

4. **What is Aspire's co-management philosophy?**
   Aspire does not replace a patient's PCP or any other specialist. Aspire's interdisciplinary team serves as an extra layer of support for the patient and his/her family. Key to Aspire's intervention are the deep working relationships their lead palliative physicians build with PCPs and specialists around the country and thoughtful coordination that wraps around each patient's individual needs. After each clinical visit, a patient's PCP and all pertinent specialists are sent a summary note via secure e-fax that includes a brief patient assessment, management plan, reconciled medication list and other pertinent details. In the event of an acute exacerbation, change in patient status or other timely event (e.g., the need for a new prescription), the Aspire clinician will pick up the phone and call the patient's relevant provider to collaborate.

5. **Does the palliative care team replace the patient's primary provider?**
   The palliative care team partners with the primary provider. The ideal palliative care is delivered as a partnership with the individual's primary provider. While the primary provider leads the care for the individual's illness, the palliative care team manages symptoms and adverse effects from treatment, coordinates care and facilitates advance care planning.

For more information, visit the Aspire website.