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The leading edge

Interview with Brad Smith, CEO of Aspire Health

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Brad Smith is the founder and Chief Executive Officer of Aspire Health, a palliative care management service that works with patients facing serious illness. Brad is responsible for the strategic vision and leadership of the organization. Brad most recently served as chief-of-staff at the Tennessee Department of Economic Development. Prior to his time in state government, Brad was the founding executive director of the Tennessee State Collaborative on Reforming Education (SCORE), a statewide education initiative and worked in the White House. Brad graduated summa cum laude from Harvard University and received an M.Phil from Oxford University, where he was a Rhodes Scholar.

Interviewer: *Why don't we start off by you telling us a bit about Aspire Health?*

Brad Smith: Aspire is a home-based palliative care physician organization. We go into cities and employ interdisciplinary teams of palliative care physicians, advanced practice clinicians (nurse practitioners and physician assistants), nurses, social workers and chaplains to care for patients who are facing advanced illness.

INT: *What inspired you to build a company focused on palliative care management for seriously ill patients***?**

BS: The way I got interested was that my brother was in medical school and took a year off to work with Atul Gawande and Susan Block, at Harvard, on palliative care research. During that time, he shared with me research from organizations that were doing a combination of home and clinic-based palliative care. As I read those articles, I was really struck by three things: palliative care programs led to high levels of patient and family satisfaction, they assisted primary care physicians with some of their most ill patients, and they were decreasing hospitalizations by 40–50%. As someone who was not in healthcare, I just thought, why isn't this happening everywhere. A few months later, my grandmother became quite sick. She was in and out of the hospital multiple times and eventually passed away in the hospital without transitioning to hospice and the experience was not ideal. So both my own personal experience with a family member as well as the prompting of my brother's research spurred my interest in launching Aspire.

INT: *So take us through the experience of an average Aspire patient and the service they might receive***?**

BS: We identify patients one of three ways: doctors can refer patients directly to our service, health plans that we are partnered with can refer patients to our service, and we also analyze health plans' historical data to identify patients who might be appropriate for our service. Once we identify our patients we call them and schedule an initial home visit with one of our clinicians. The initial home visit typically lasts 90–120 min and is primarily focused on building a relationship with the patient and their family. During this visit we also complete a detailed medical history and look to understand the social, emotional, and spiritual aspects of the patients' life. We really want to know what matters to them most. We will then typically come back to see the patient every two to four weeks depending on their clinical status. We customize the care team to the patient's needs, for some patients the chaplain or the social worker might be a more integral part of the care team, but it depends on the patient. We also offer our patients a 24/7 on-call service where they can reach a clinician for emergent situations.

INT: *On average, how long are you helping to care for patients before they transition to the next stage of their care?*

BS: On average, patients are in our care for about eight to nine months. About 75% of the patients that pass away transition to hospice before they pass and their average amount of time in hospice is 75–85 days. So, on average we are engaging with patients approximately one year before they pass away. Of course, there is a huge distribution around that average.

INT: *What were some of the key learnings that the organization made in developing its clinical model?*

BS: The care we provide is really based around the relationship between the clinician, the patient, and the family. For a patient to call us in the middle of the night or begin a conversation about their goals, they need to trust us. As a result, we have really tried to keep that relationship at the heart of what we do. We also have tried to design our clinical interactions around the needs of the patient. Instead of having clinical protocols which dictate our interactions, we realized that such protocols might differ from a patient's needs and desires. Instead we worked with our clinicians to develop clinical guidelines that shape the way we think about our work, but really it's about responding to each patient's individual needs.

INT: *From a business perspective, how are you navigating the changes in reimbursement policies and the transition to value-based payments?*

BS: Today we don't see traditional Medicare patients because the

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Centers for Medicare and Medicaid Services (CMS) have not built a mechanism to reimburse home-based palliative care in a way that's sustainable. Right now, we are primarily partnered with health plans, Medicare Advantage plans, and managed Medicaid plans who are taking risk for their patients, but there is a growing group of providers such as health systems, accountable care organizations, and independent practice associations, who are starting to take risk for their patients. We have found that as these provider groups take on risk, partnering with them has been particularly helpful because it really strengthens the relationship between the patient, their non-palliative care providers, and our clinicians.

INT: *Your background is in economic and education policy, now having moved over to the entrepreneurial side of healthcare, what have been some of your biggest learnings during this process?*

BS: As someone who was not previously in healthcare, a realization for me was that sometimes things just don't make sense and it turns out that there are a lot of historical reasons why things work the way they do. The healthcare system is very specific, very intricate, and very complex. Understanding how different health plans and provider groups work together as well as understanding the incentives of different stakeholders and the variation that exists under different policy or payment arrangements is extremely complex. Creating a service within that system of intricate incentives and operational structures has been a very interesting and rewarding challenge.