

Comprehensive, Continuous Chronic Care Management in the Home

Executive Summary

Chronic diseases affect approximately 133 million Americans regardless of their age, race or economic status.¹ Over the next twenty years, the number of Americans with chronic conditions will increase by 37%.¹ Putting additional burden on the Medicare system, these high cost, chronically ill beneficiaries see an average of seven physicians per year, fill an average of 20 different prescriptions,¹ account for 76% of all hospital admissions, and when compared to individuals without a chronic condition, are 100 times more likely to have a preventable hospitalization.² In the current system, there are few incentives to coordinate care across providers and service settings.

People with multiple chronic health problems recognize the difficulties with the current health care financing and delivery system and are looking for fundamental changes. In addition to improving the coordination of care, the health care system must place a higher priority on prevention to avert disease or slow its progression. For health care providers, slowing disease progression should be as important as treating acute episodes of an illness.

The prevalence and costs of chronic health conditions in the United States have wide-reaching, negative outcomes and consequences. Currently, 12% of the Medicare population accounts for 69% of costs,⁵ and 96% of program spending is consumed by beneficiaries with more than

“We’re not getting what we pay for. It’s just that simple.”

– Denis Cortese, President and CEO of Mayo Clinic⁴

one chronic disease.¹ Care for chronically ill patients is costly and generally leads to unnecessary hospitalizations, nursing home placements, and duplicate diagnostic tests. Medicare expenditures reflect this trend: 66% of Medicare dollars are spent on beneficiaries who have five or more chronic conditions.¹ We must find a way to reduce costs and deliver higher quality care to our chronically ill Medicare beneficiaries.

And, reducing rehospitalization rates, particularly for Medicare beneficiaries, must be a top priority for sustainable health care reform. Recent data released on rehospitalization rates among Medicare



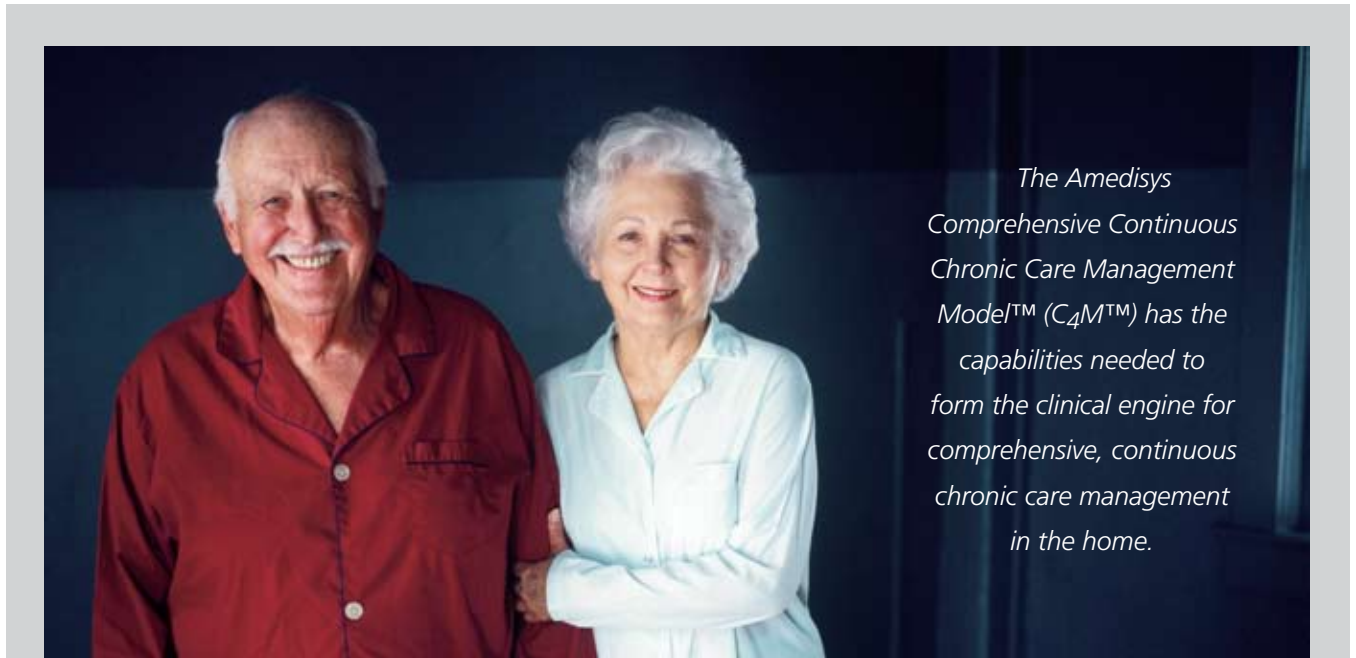
Reform *“is not just a challenge, but also an opportunity to improve the healthcare that Americans rely on and to bring down the costs that taxpayers, businesses, and families have to pay.”*

Then President-elect Obama reported by the Bureau of National Affairs³

beneficiaries is revealing: 19.6% of Medicare beneficiaries discharged from a hospital were rehospitalized within 30 days.⁶ Additionally, 34% were rehospitalized within 90 days of discharge.⁶

According to former Senator Bill Frist, “healthcare reform begins with payment reform.”⁷ Adjusting the systems of financing while delivering care to better meet the needs of the chronically ill will require a renewed focus on prevention, early detection, and the adoption and implementation of coordinated chronic care management plans for long-term success.

A new scalable model of care that is



in an open delivery system is imperative for addressing the financial and quality issues facing the US health care system. Of particular importance is a delivery system that facilitates high quality, evidence-based care for an ever-growing, chronically ill, elderly population. The medical home concept, which is being discussed by many at local, state and federal levels, is a

management in the home. Designed to deliver care to the most complex, chronic and costly population in the comfort of their own home, the model combines the existing home care infrastructure — comprehensive, in-home assessments; patient-centered plan of care development; multi-disciplinary in-home care delivery; coordinated chronic care management; and in-home, end-of-life

working with policy makers, researchers and others in a variety of chronic care management demonstrations. Additionally, Amedisys is a founding member of the Alliance for Home Health Quality and Innovation, an association of the home care leaders that proactively informs and educates decision makers and the public on the value and promise of home health care in helping to address the significant challenges that face our nation's health care system.

A new model of care that is scalable nationwide in an open delivery system is imperative for addressing the financial and quality issues facing the US health care system.

Through these various endeavors, Amedisys is positioning itself to redefine the role of home care within the health care continuum for the chronically ill, complex patients who are currently costliest to the system. Amedisys has developed a clinical model that we believe realigns health care delivery to meet the needs of this fragile population while improving outcomes and patient satisfaction with the potential to save the Medicare benefit billions of dollars.

piece of the puzzle, but will not be able to accomplish this goal of a new model of care on its own.

The Amedisys **Comprehensive Continuous Chronic Care Management Model™ (C4M™)** has the capabilities needed to form the clinical engine for comprehensive, continuous chronic care

care. We also have the capabilities to use advanced information and communication technologies, as well as sophisticated clinical capabilities, to provide intensive home-based health care.

In addition to adapting current processes and systems to better address the needs of these patient populations, Amedisys is

Comprehensive, Continuous Chronic Care Management in the Home

Americans are living longer than any previous generation. Along with the aging of the population, this country has also experienced a substantial increase in the number of Americans living with chronic health conditions. While health care needs have progressed, the health care system has not evolved nor realigned itself to meet the needs of those with complex chronic illnesses.

As an organization, we recognize that a serious problem is facing our country: **growing numbers of elderly individuals with chronic conditions seeking health care in a system that is ill prepared to respond to this new dynamic.**

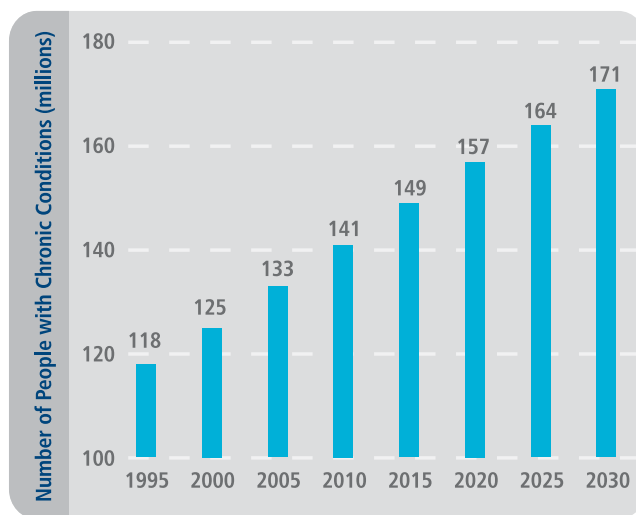
Chronic diseases affect approximately 133 million Americans of all races and economic statuses.⁸ Within another ten years, that number will increase to over 157 million.⁸

Chronic illness has become the key health care concern of the Medicare population. Within a year, the average Medicare beneficiary sees seven different physicians while filling at least 20 prescriptions.¹ This information alone should raise concerns about our current health care system and its ability to coordinate care for people with chronic conditions. This chronically ill population requires different services and support than is currently covered under the traditional acute care benefit structure of Medicare. In the current system there are few incentives to coordinate care across providers and service settings. Too frequently, individuals with chronic

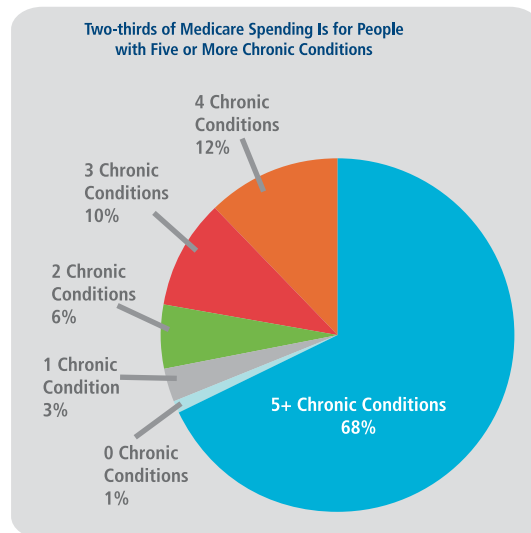
conditions report receiving conflicting advice from different physicians and differing diagnoses for the same set of symptoms. Drug-to-drug interactions are also common, often resulting in unnecessary hospitalizations, readmissions, emergency department visits, and even death. Elderly individuals with multiple chronic health problems, along with their caregivers, recognize the difficulties with the current health care delivery system and are looking for fundamental changes.

The costs of caring for people with chronic conditions are staggering. In addition, disparities in care are pervasive for those with chronic conditions. The Dartmouth Atlas study reveals that chronically ill patients in different parts of the country receive varying levels of care in terms of quality, frequency, and cost. Results indicate that spending on these patients varies by a factor of almost three.⁹

Additional data indicates that spending on 12% of the Medicare population accounts for 69% of costs⁵ and 96% of Medicare spending is consumed by individuals with more than one chronic disease.¹ Two-thirds of those dollars are spent on Medicare beneficiaries who have



Wu, Shin-Yi and Green, Anthony. Projection of Chronic Illness Prevalence and Cost Inflation. RAND Corporation, October 2000.

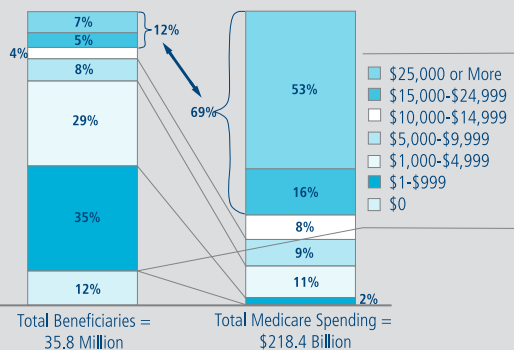


Johns Hopkins University, Partnership for Solutions, September 2004 Update.

five or more chronic conditions.¹

Lack of care coordination leads to fragmented care and has a detrimental impact on elderly patients with chronic conditions, particularly when they are hospitalized. The most vulnerable time for

Distribution of Fee-for-Service Medicare Beneficiaries and Per Capita Medicare Spending, 2002



Cubanski J, Voris M, Kitchman M, Neuman T, Potetz L. Medicare Chart Book. 3rd ed. Menlo Park, Calif: Henry J. Kaiser Family Foundation; Summer 2005

patients is at the point of discharge, and, in many cases, patients who are transitioned to a home or a community-based setting are ill-prepared to self-manage their condition. To make matters worse, the physician(s) treating a patient during their hospital stay may not be the same physician(s) treating the patient once they are discharged. As noted in a recent New England Journal of Medicine publication, “rehospitalization is a frequent, costly, and sometimes life-threatening event that is associated with gaps in follow-up care.”²⁶ While much is to be learned about rehospitalization patterns, particularly among Medicare beneficiaries, recent data reveals five key trends related to rehospitalization (see listing). This same research further notes that “from a systems perspective, a safe transition from a hospital to the community or a nursing home requires care that centers on the patient and transcends organizational boundaries.”²⁶ Unfortunately, current payment systems, including Medicare, do not encourage providers to coordinate a patient’s care during transition from facility-based care back to the community.

Potential Solutions

In his book, *Critical: What We Can Do About the Health-Care Crisis*, former Senator Tom Daschle articulates the solution to today’s growing problem. “Care for people who are chronically ill has to be collaborative, since it often involves multiple providers. Communication between patients, doctors, and caregivers is crucial, and health information has to follow patients as they move

from home to doctor’s office to hospital to nursing home and back. And yet too often, doctors and hospitals in our country operate in isolation, providing care without having complete information about a patient’s condition, medical history, or previous care they might have received.”²¹⁰

Experts and policy makers recognize the failure of the current Medicare fee-for-service model to adequately manage chronic diseases. As a result, Medicare has launched initiatives seeking to test the value of alternate approaches to improving care for patients with chronic conditions. These include the Medicare Case Management

Demonstration, Coordinated Care Demonstration, Disease Management Demonstration, Care Management for High Cost Beneficiaries Demonstration, Special Needs Plans (SNPs), End-Stage Renal Disease Managed Care Demonstration, and Medicare Health Support.¹¹ Despite all the efforts, no viable, scalable, long-term solution has emerged.

However, there are several models in operation demonstrating substantive results for chronically ill, elderly patients.

The Geisinger Health System, located in Pennsylvania, has integrated new and redesigned care processes, focusing on the use of technology in a highly collaborative health care environment. The system adopted the use of a unique medical home concept facilitated by a personal health navigator. Emphasizing the use of evidence-based care coordination for patients with chronic diseases, early results show great promise. Preliminary data show a 20 percent reduction in hospital admissions (all causes) and a 7 percent reduction in total medical cost savings.¹²

The Department of Veterans Affairs (VA) has developed a model for managing elderly veterans with chronic conditions in the home setting. The Home Based

Research on rehospitalization rates among Medicare beneficiaries reveals five key trends.

1. Targeted interventions at discharge can reduce rehospitalization rates whereas coordination-of-care interventions limited to a community-based setting have not shown results in reducing rehospitalization rates.
2. Hospital and physician collaboration is important to improve the effectiveness of a patient’s follow-up care.
3. Patients discharged after a surgical procedure can benefit from prior medical follow up.
4. Given that 90% of rehospitalizations within 30 days are unplanned, rates are not driven by clinical practices within the initial hospitalization or by profit driven division of services into multiple hospitalizations.
5. Statewide variation in hospitalization rates implies improvements on a nationwide scale are possible.⁶

source: N Engl J Med 2009; 360:1418-28

Primary Care (HBPC) program targets frail, chronically ill veterans and delivers longitudinal health care services in the home. In contrast to delivering episodic home care (i.e.: current Medicare home care benefit limited to 60-day episodes of care), the model provides ongoing, continuous monitoring for chronically ill patients. Use of an interdisciplinary team, including medical directors, program directors, nurse practitioners, physicians’ assistants, RNs, licensed practical nurses, social workers, dietitians, rehabilitation professionals, pharmacists, and program assistants, comprises a key component of the program. 2006 outcomes data reveal a 27% reduction in hospital admissions and a 69% reduction in inpatient days of care after admission to a HBPC program.¹³

A recently proposed concept, termed “the other medical home,” advocates the expanded use of in-home health care resources to treat Medicare’s most chronic patients. The concept calls for adoption of the Independence at Home legislation, relaxation of the homebound status for patients, and expansion of the home care episode to include continuous, routine care management.¹⁴

The **Care Transitions model** is another approach to managing chronically ill patients. With a focus on unstable patients through the care continuum, the model focuses on the events occurring between transfers from one health care setting to another, also known as transitional care.¹⁵ Transitional care is defined as:

“The area of healthcare that is primarily concerned with the brief interval that begins with preparing a patient to leave one setting and concludes with being

received into the next setting.”¹⁵

This model focuses on medication management; use of patient-centered personal health records; emphasis on timely physician follow up- both specialty and primary care; an understanding of the red flags that indicate an exacerbation of a patient’s condition as well as responses.¹⁵

These models use interdisciplinary health teams, targeted technology, and home-based clinical monitoring. Amedisys has expanded on basic chronic care principles to create a new model of care for chronically ill patients.

Beyond Home Health Care: The Amedisys Value Proposition

Amedisys believes home health care providers must be the care coordination and care management engine driven by physicians for chronically ill patients. No other health care provider is better poised to facilitate a physician driven chronic care management infrastructure. Amedisys clinicians deliver care to more than 300,000 patients a year throughout the country, most of whom have a high acuity level. The average Amedisys patients are between 80 – 84 years of age, and takes 12 – 13 medications on average per day. Amedisys patients clearly have a higher complexity level than a typical Medicare beneficiary.

In preparation for developing a new model for managing elderly chronic patients in their home, Amedisys has studied the existing models to identify common elements of success among the varying models. The result is a new Amedisys model, designed to deliver evidence-based, coordinated care for chronically ill,

What is C4M?

C4M is defined as:

The delivery of skilled health care in the home by an integrated team of health care professionals that provides chronically ill patients the following services, from early disease states through the end of life:

- *a comprehensive and continuous assessment of all medical, psychological and social conditions and needs;*
- *effective teaching, continuous monitoring, and reinforcement of evidence-based self-management and independence skills;*
- *collaborative and continuous care coordination.*

elderly patients, known as **Comprehensive Continuous Chronic Care Management in the Home** or **C4M**.

Amedisys created this C4M model to deliver a more advanced level of in-home care to elderly, chronically ill patients. The infrastructure of the Amedisys model, inspired by Dr. Ed Wagner’s Chronic Care Model, builds upon key principles of adult learning for a targeted emphasis on self-management skills.¹⁶ Originally created to improve the standard of care within a traditional episode of home care, the model combines the existing home care infrastructure with additional information and communication technologies and enhanced clinical capabilities. Amedisys believes that the model can be successfully employed as the cornerstone of a clinical

care engine that can be integrated into open model health care delivery systems of all sizes, creating a platform for in-home comprehensive, continuous chronic care management that is scalable nationwide.

Designed to deliver care to the most complex, chronic and costly patients in the comfort of their own homes, the proposed model combines the existing home care infrastructure — comprehensive in-home assessments; patient-centered plan of care development; multi-disciplinary in-home care delivery; coordinated chronic care management; and in-home end of life care — with care coordination across providers, capabilities to use advanced information

and communication technologies as well as clinical capabilities to provide intensive continuous home-based health care (“Hospital at Home”). *Existing Home Care Infrastructure components described below.*

Home Care Infrastructure

The existing home care benefit provides the foundation for comprehensive, continuous, chronic care management for elderly, homebound patients and pays for the critical components of the new infrastructure.

Because of this, we believe home care should play a larger and more expanded role in the delivery of care to elderly individuals

with complex, chronic conditions.

With additional integrated capabilities, we foresee that the existing home care infrastructure can serve as a platform for a scalable, nationwide system of managing chronically ill patients in America. Information and communication technologies as well as clinical enhancements leveraging the home care infrastructure create an integrated model of care delivery. Amedisys has identified additional model capabilities needed to form the clinical engine for comprehensive, continuous chronic care management in the home and is actively pursuing full model development.

Existing Home Care Infrastructure

In-Home Assessment – The in-home assessment is the entry into the care setting. The assessment, which typically takes 2 hours to perform, evaluates a patient’s clinical, functional, psychosocial and behavioral status as well as caregiver support. The Outcome and Assessment Information Set (OASIS) required to be completed by all home health care providers is embedded into our comprehensive clinical assessment.

While in the home, home care clinicians may observe safety hazards, medication discrepancies, and/or social and environmental challenges unrecognizable in a office-based setting. With the exception of house call physicians, no other stakeholders within the health care setting have access to first hand observation of a patient’s home environment.

Technology advances allow for all assessment data to be captured electronically so that a patient’s plan of care can be created based upon accurate, real-time, reliable information prior to submission to a patient’s physician.

Plan of Care development – Using the firsthand data gathered in the assessment, clinicians prepare a patient-centered plan of care that takes into account all aspects of the patient’s health condition, his/her social and emotional environment, and the dynamics within the home.

Skilled nursing staff who are competent in plan of care development for elderly patients with chronic diseases perform this function.

In-home care delivery- a multi-disciplinary approach – Clinicians can be deployed to a patient’s home anywhere in our national service area at any time. Physicians can deploy a health care professional to the

home in the event an observation is necessary for all elderly patients. This prevents unnecessary exacerbations for patients with chronic diseases.

Physician, skilled nurse, rehab, therapy, and medical social services are performed in the patient’s homes.

Coordinated Chronic Care management – Clinicians deliver learning in a patient’s home based upon an established plan of care — teaching patients about their own chronic diseases and how to self-manage their individualized health care needs. In-home clinician visits provide an opportunity to teach and reinforce patient-centered, self-management strategies to both patient and family caregivers.

By visiting patients in their home, clinicians can also observe patient’s dietary trends: what a patient and his/her caregiver eats, how he/she cooks, how active a patient is, and the safety of his/her home. This is critical to understanding what self-management strategies should be employed for a patient based on his or her specific needs.

In- Home Hospice care – End-of-life care in the home for elderly patients is critical. Amedisys’ hospice and home health care providers work closely to provide complementary care for patients. Providing an individualized, family-centered approach to caring for terminally ill patients, hospice services can be a valuable resource to physicians planning for end of life care.

Amedisys Information and Communication Technology Capabilities

1. Clinical software system - Point of Care Technology

Amedisys field clinicians utilize point of care laptop devices to manage homebound patients. These devices are used to collect assessment data, assist in monitoring a patient’s medical condition, maintain a patient’s medical record, schedule appointments, monitor medication and track clinical protocols relevant to a patient’s care as well as to generate appropriate medical orders. These devices alert the clinician to possible prescription interactions and walk a clinician through a disease protocol once the patient’s information and vital signs have been entered. Currently, we have over 12,000 clinicians using this system.

2. Provider communication technology: Mercury Doc

Amedisys has developed a proprietary, web-based technology that delivers data on patient’s clinical events in the home to physicians electronically for care management and oversight. The technology provides physicians with online access to a patient’s graphed and trended vital signs as

well as medication, allergy and pharmacy information. Rolled out to the market in August 2007, we currently have over 3,300 physicians actively using the system.

3. Expanded Collaborative Care Technology

Amedisys is working actively to integrate a collaborative tool for care coordination into the existing care delivery platform. Part of this initiative includes connecting communities of physicians, their staff and patients to proactively monitor patients’ health to redefine the patient experience. This technology will facilitate care coordination and quality improvement with embedded clinical decision support tools and clinical registries. It offers provider-patient messaging, preventive care reminders and care plan monitoring/reporting. Clinical protocols facilitate timely and appropriate interventions driven by telemonitoring of a patient’s condition. With this expansion of technology, Amedisys will have the capability for patients and their respective care team to receive education and reminders that improve treatment and medication adherence.

4. Nurse Call Center

Encore®, the Amedisys nursing call center, provides telephonic care management

services to help Amedisys patients maintain an optimal level of health, augmenting home health services, both during the 60 day episode of care and after discharge from home health care services. The center also facilitates the collection of patient/caregiver satisfaction survey data. The call center has the capability to initiate local community support resources for patients and caregivers, guide patients on wellness/disease prevention programs, and perform patient reminders regarding - preventive visits, office visits and vaccinations, as well as support pre/post visit follow-up with patients and caregivers.

Encore call center value lies in the ability to reduce hospitalizations by delivering continuous care coordination to chronically ill, elderly patients. A recent report, issued by Mathematica Policy Research, “The Promise of Care Coordination,” highlights successful models for reducing hospitalization among Medicare beneficiaries. The publication outlines continuous care coordination as a successful program component worthy of further exploration.¹⁷ And, preliminary internal data on the Encore call center supports this premise that continuous post-episodic communication with patients may lead to a reduction in rehospitalizations

External Benchmarks

Most recent information reveals readmission rates are 12% to 14% on average per admission.

<30 Days	4.7% - 6.2%
31 – 60 Days	8.1% - 10.7%
61 – 90 Days	6.5% - 12.8%
91+ Days	8.2% - 14.1%

Sources:

1. Dept. of Health and Human Services-Office of Inspector General 2000, 2002, 2004, 2005
2. 2002 NHS Trust Plan and Report
3. 2004 Institute for Healthcare Improvement
4. Health Care Cost Containment Council 2005

Amedisys Benchmarks

Most recent information reveals readmission rates are 4.09% to 5.46% on average per admission.

<30 Days	1.48% - 1.60%
31 – 60 Days	1.17% - 1.76%
61 – 90 Days	0.62% - 1.32%
91+ Days	0.70% - 0.90%

Sources:

1. Post episodic DM call center results
2. 14,313 patients tracked over a 6 month period

among home care patients. Self-reported Amedisys data on patient rehospitalization rates is compared to external benchmarks on page 5.

5. Telehealth Monitoring

Amedisys provides patients with access to home monitoring systems that enable home care clinicians to remotely monitor patients, creating a link between homebound patients and physicians via the home care clinician. This routine monitoring enables patients to become more educated about their personal healthcare needs and more informed consumers of health care. Additionally, physicians have access to trended patient data and outcomes, allowing them to make more informed treatment decisions.

6. Future Integration Opportunities

Integration of additional point of care diagnostic testing, including portable x-ray technology, MRI (magnetic resonance imaging) and CT (Computerized Axial Tomography) scans, and specialized laboratory tests could expand the scope of care coordination and the new model, paving the way for enhanced mobile medicine capabilities in the home.

Additional Clinical Capabilities

1. Amedisys Chronic Care Coordination Clinical Model

In addition to the above-mentioned capabilities, Amedisys is currently testing an enhanced clinical care delivery model for managing elderly patients with chronic conditions in the home.

An illustration of the model’s capabilities: A patient is admitted to Amedisys, and upon admission, assessment data is collected via the point of care laptop. Predictive modeling technology is used to stratify the patient according to risk level, based upon risk of hospitalization. A centralized care team member monitors the patient for appropriate intervention protocols, using evidence-based practices. A community-based clinical manager delivers local care coordination by monitoring clinical and behavioral developments, social services needs, and implementation of individualized care plan components. A high-risk patient is then managed via the care team of an appropriate chronic care portal, which provides patient-centered, comprehensive care management. Common treatment modalities in the chronic care

portals include:

- *Health coaching model*
 - *Comprehensive pharmacy/medication evaluation*
 - *Telehealth remote monitoring*
 - *Interactive voice response (IVR) telephonic intervention*
 - *Disease specific best practice treatment modalities*
- (All part of a Risk Modification Program)*

Amedisys internal data reveals that patients with the highest propensity for hospitalization are those with congestive heart failure, diabetes, and high risk of falls. Thus, the initial clinical model targets these conditions.

2. Hospital at Home: An Alternative to Facility-Based Care

An expanded capability of the clinical engine is to provide acute, hospital level care in a patient’s home using a hospital at home model. Use of this model, which has proven to be efficacious and cost-effective for targeted chronic conditions, in combination with the existing home care infrastructure can provide a viable alternative to facility-based care for patients managing acute

Amedisys Home Care Capabilities vs. Traditional Medicare Home Care

Amedisys’ Chronic Care Management

- *Focuses on chronic, complex, elderly patients*
- *Physician led with interdisciplinary team*
- *Delivers continuous care management*
- *Patient not required to be homebound*

Medicare Home Care Benefit

- *Available to all qualified Medicare patients*
- *Physician led with or without team*
- *Episodic care delivery*
- *Homebound status required*

exacerbations of chronic conditions.¹⁸ Amedisys believes patients should be discharged to the hospital, the most expensive care setting, only after ALL attempts to care for the patient in the home (community based setting, the least expensive care setting) have been deployed.

Comprehensive, Continuous Chronic Care Management in the Home

Amedisys believes its model will deliver higher quality, patient-centered, and cost effective care for elderly individuals with chronic illnesses. In contrast to the fragmented current delivery system, this model is clearly distinguished from other non-comprehensive attempts to address the chronic care problems plaguing the American health care system. The key differentiation factors

between the Amedisys model and earlier endeavors include:

1. Physician driven - Unlike prior attempts to systemically manage chronically ill patients, this model is a relationship-based, physician-led care delivery model. A physician-driven approach to care delivery for this targeted patient population is critical.

2. Relationship based disease/care management - The Amedisys model leverages the unique relationship forged between elderly, homebound patients and their home care clinicians. Unlike facility-based settings, home care clinicians deliver care in a patient's home, and this often creates a unique bond between patients and clinicians that leads to a more trusting, open relationship. Patients often rely upon their home care clinician to assist with understanding and implementing physician's orders. This relationship is a key driver for collaboration between patients and health care providers, thereby

There are other key benefits associated with the Amedisys C4M model:

- *Uses real-time data to prevent clinical exacerbations versus traditional use of claims data, which is post-event.*
- *Amedisys believes elderly individuals with chronic, complex conditions receive higher quality, patient-centered care.*
- *Amedisys believes costs of care delivery are considerably lower than traditional forms of facility-based care delivery for elderly patients.*
- *Can be integrated into multiple health care settings that seek to deliver high quality, cost effective care to elderly patients with chronic conditions. Unlike others, the Amedisys model is designed to operate in an open system environment versus a closed system. (i.e. VA HBPC Program)*
- *Amedisys model creates a platform for payment reform within the current health care system that leverages the existing, less expensive home care benefit.*
- *Amedisys model leverages the \$350 billion in voluntary caregiver services and support provided by family and friends each year.²⁰ Evidence shows that most caregivers are ill-prepared for their role and provide care with little or no support. This new model of care recognizes the important role of these individuals and provides them the support and education they need to care for their family member.*
- *Amedisys model is scalable and can expand to a nationwide coverage area of health care clinicians that can be deployed to a patient's home anywhere across the country at any time.*

creating opportunities for learning and behavioral modification.

3. Early recognition and rapid clinician deployment - The Amedisys model deploys care management capabilities that provide physicians around the country with a rapid response mechanism for managing chronically ill patients. If a patient has an exacerbation, home care clinicians can be deployed to patients' homes anywhere around the country very quickly. Consequently, this rapid deployment and intervention can prevent unnecessary hospitalizations.

4. Home-based alternative to facility-based care for acute exacerbations (for targeted conditions) – Preliminary results from one study on the hospital at home model revealed a 32% cost savings in comparison with a traditional hospital stay. In addition to these cost savings, results of the studies on the model also reveal fewer clinical complications.¹⁸

5. Home-based End-of-Life Care - The use of hospice services for chronically ill patients can impact quality and overall costs for elderly patients. According to a recent Duke University study, increasing the length of hospice care for the majority of Medicare hospice patients reduces Medicare program expenditures during the last year of life by an average of \$2,309 per hospice user.¹⁹

Future of Health care

There is a general recognition among patients, providers, and the public that significant changes within the health care system are needed to improve chronic care delivery in this country. In a poll conducted by the Commonwealth Fund, respondents

were asked about the magnitude of changes in the delivery system necessary to achieve significant gains in the quality and efficiency of care in the U.S. Eighty-nine percent responded that fundamental change is required in the way most of the U.S. delivery system is organized.²¹

Amedisys understands that as chronic conditions dominate the agenda of health care concerns in our country, major changes are in order to address the needs of people with non-acute, ongoing health care concerns. Care provided in the current acute, episodic model is not cost-effective and often leads to poor outcomes for patients with chronic conditions. In clinical practice, chronic conditions require continuous care and coordination across health care settings and providers.

The goal of a new chronic care model is early symptom recognition with interventions that maintain health status and minimize episodes of acute exacerbations of chronic illness. When acute exacerbations do occur, a chronic care model brings together a coordinated array of appropriate services that restore the individual to the highest possible state of functioning and improve quality of life.

A new chronic care model will also focus on the delivery of comprehensive, compassionate care at the end of life. The most important aspect of quality at this time is understanding and complying with the wishes of the patient and family. By integrating care within the chronic care team, this model allows for patient and family participation in decision-making, meeting their needs at the most crucial time.

Amedisys is positioning itself to be the

provider of choice for elderly patients with chronic conditions. Recognizing that solutions will only come by re-thinking how our health care financing system values and pays for the care received by people with chronic conditions, Amedisys believes that payment reform is not only imminent but necessary and must be value-based.

Therefore, Amedisys will continue to stay focused as the low cost provider of high quality health care services. By providing community-based care in lieu of facility-based care, we have an opportunity to achieve significant cost savings for the highest cost Medicare beneficiaries.

Amedisys believes that innovative providers in the home care industry have a unique opportunity to evolve into a more active stakeholder within the health care continuum, serving as an alternative provider to facility-based care for chronically ill patients. To facilitate this evolution, the organization is actively working to integrate its model into key pilot projects and is closely monitoring key legislative initiatives and health care payment reform models including:

- *Medicare Medical Home Demonstration*
- *Independence at Home Act*
- *Payment bundling — including the concept of Accountable Care Organizations (ACOs)*

Additional noteworthy reforms are needed to further drive value within health care for the chronically ill elderly population, which includes:

- *Expansion of the home care benefit from a traditional episode-based benefit to include ongoing care management*

for chronically ill, elderly patients. We envision that delivery of continuous care extending beyond the traditional 60-day episode for high risk patients can reduce unnecessary hospitalizations, yielding substantial cost savings for the sickest and costliest patients.

- *We also believe that the homebound status requirements should be relaxed so that the home care industry can deliver care to high-risk Medicare patients with multiple co-morbidities.*

To that end, Amedisys has launched several, additional, significant, long-term, strategic initiatives to prepare for an evolution of the home care industry:

1. Founding Member of the Alliance for Home Health

Quality and Innovation - The Alliance for Home Health Quality and Innovation is a national consortium of home health care organizations and providers that raises awareness about home health care and its proven ability to deliver quality, cost-effective, patient-centered care for patients.

William F. Borne, Amedisys founder and CEO, serves as chairman of the Alliance and is actively working to change the value proposition for home care within the health care delivery system.

2. Pilot/demonstration projects - Amedisys is actively working with several Quality Improvement Organizations (QIO) on a Care Transitions Demonstration project for Medicare beneficiaries as well as with the Centers for Medicare & Medicaid Services (CMS) in the Post Acute Care Demonstration project. Amedisys is also actively seeking other CMS demonstration projects to test alternate models for comprehensive, continuous chronic care management.

Amedisys is positioning itself as an alternate health delivery vehicle to better allocate our limited health care resources to provide people with access to high-quality care and appropriate services that maintain health and functioning in the face of chronic disease progression and ensure that this care is coordinated across multiple providers and payers, particularly through the end of life.

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