

Amedisys Home Health Services

May 4, 2009

I am pleased to release our most recent publication, *Amedisys Home Health – Comprehensive, Continuous Chronic Care Management in the Home*. This white paper, which outlines Amedisys' vision for transforming health care for chronically ill, elderly Americans, provides a framework for better understanding the value of health care in the home for this fragile population.

Home care is in the unique position to be the driver of the value proposition in health care reform as it relates to this costly and complex population. As an important stakeholder in the health care delivery system, we have an obligation not only to deliver the highest quality care to the patients entrusted to us but also to continually seek opportunities that drive value for our patients, our overall health care system and our shareholders.

Now more than ever, we must take a closer look at the opportunity to deliver outcome-based care for chronically ill patients in the home environment. And, after reviewing the overall health care delivery system and proven models for the chronically ill, elderly patient population, two key observations are noteworthy.

1. Problem:

Current care delivery methods and the clinical needs of patients are not aligned with the chronic population. The use of acute facilities, such as hospitals, has value for patients with trauma and emergency care needs as well as surgery, obstetrics, first time diagnostics and others. However, 50% or more hospital admissions represent this population of patients with chronic and complex diseases. For these patients, a facility-based setting is not the best place when conditions of chronic exacerbations occur.

Solution:

Health care reform needs to evaluate the best clinical model that will realign clinical care and delivery methods that best match the needs of the patients being served.

(see page 2)

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2. Problem:

Patients have limited time with physicians in facility-based settings (i.e.: hospitals and physician's offices).

During a patient's stay, discharge planning or an office visit, a physician spends a very small amount of time with that patient. Nurses and allied health professionals manage the one-on-one coordination process and activities associated with overall care of that patient. The same holds true for outpatient and rehabilitation facilities and managed care organizations.

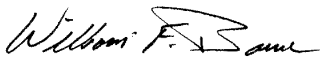
Solution:

Nursing and allied health professionals are vital to all health care functions. Therefore, it makes sense to have nursing and allied health as an integral part of the care delivery designed to address the ever-growing complex, chronic population, particularly within a home or community based setting.

As a nation, it would be valuable to consider using an infrastructure that already exists. Nurses and allied health professionals deployed nationwide currently care for this costly population. Let's take advantage of this infrastructure and make it a driver of health care reform as it relates to care coordination and chronic care. Simply put, home health care is the missing link to caring for this population cost effectively, comprehensively and compassionately.

I trust you will find this paper useful and informative. The dynamics of rapidly evolving health care reform require this to be a living document. As such, it will be updated as needed. Please refer back on a regular basis for current versions.

Sincerely,



William F. Borne
CEO, Amedisys, Inc.