C_4M®

A Model For Delivering Comprehensive, Continuous, Chronic Care in the Home

Amedisys
Bringing Home the Continuum of Care

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"The rising cost of health care is the nation's number one deficit problem — nothing else even comes close."

– President Obama
Speech, September 9, 2009

INTRODUCTION

Today, there are more than 10 million Medicare beneficiaries with five or more chronic conditions. These beneficiaries, while representing only 23% of total program enrollment, account for 68% of Medicare spending.[i] The current delivery system, with its siloed payment systems and lack of care coordination, fails to promote a coordinated, cohesive model of care focused on long-term patient outcomes, which is particularly important for beneficiaries with multiple chronic conditions.

Congress, in the Affordable Care Act (ACA), attempts to address some of these system failures through delivery and payment system reforms. The ACA includes provisions to hold providers accountable beyond their site of care, for example, by penalizing hospitals for readmissions within thirty days. These delivery system reforms include pilots and demonstrations to test new payment and delivery models, such as accountable care organizations (ACOs) and medical homes, as well as more targeted initiatives, such as bundling, to promote greater coordination and management of patients across settings of care.

The ACA takes some significant steps forward in promoting greater coordination and management for patients with chronic conditions. Providers with experience managing populations with chronic conditions have valuable experience to inform some of these new payment models and help the Centers for Medicare and Medicaid Services (CMS) achieve its goals. The C_4M® – Comprehensive, Continuous Chronic Care Management model offers important insight into some of the key parameters and characteristics of programs designed to manage these high cost, clinically complicated patient populations. In addition to managing these complex populations, C_4M® reaches patients where they live, honoring the preference of most Americans to remain in their homes. The C_4M® model could provide a useful framework in the design and implementation of new payment models.

THE PROBLEM

The first Baby Boomers will become eligible for Medicare in 2011. By 2030, six out of ten Baby Boomers, or 37 million people, will have more than one chronic condition.[ii] More effective care and management of these beneficiaries will be essential to ensuring the future viability, quality, and cost effectiveness of the Medicare program.

A total of 83 percent of Medicare beneficiaries have at least one chronic condition, while 23 percent have five or more chronic conditions.

Patients with chronic conditions tend to be very high cost and make up a disproportionate share of Medicare spending. The highest cost beneficiaries are those with multiple specific chronic diseases and functional disabilities. A total of 83 percent of Medicare beneficiaries have at least one chronic condition, while 23 percent have five or more chronic conditions. Medicare beneficiaries with the top ten chronic conditions accounted for 50% of Medicare spending from 1987 through 2006.[iv] According to the Congressional Budget Office, even a small percentage reduction in Medicare spending for this group of high-cost beneficiaries" could lead to large savings for the Medicare program."[v] This will become increasingly important as the number of people with chronic conditions is also increasing. Beneficiaries with multiple chronic conditions (3 or more) are the fastest growing segment of the Medicare beneficiary population.[vi]

The current Medicare payment system is siloed with separate payment systems for each setting of care. The provider is reimbursed based on the care provided in its silo and there is limited coordination and accountability across silos for cost of care or outcomes. This lack of coordination across sites of care contributes to the high rate of re-hospitalizations among Medicare beneficiaries. Recent studies suggest that within 30 days of being discharged from a hospital, a Medicare patient has a 20% chance of returning resulting in between $12 and $15 billion of costs annually.[vii]

Experts and policymakers recognize the failure of the current Medicare fee-for-service model to adequately support chronic disease management. Although no viable, scalable, long-term solution has been identified to date, instructive models have emerged that can serve as a framework for future delivery system reform.

ROLAND's Story
A Case Study on the Need for Better Home-Based Care Management

Roland* had end stage kidney disease, adult-onset diabetes, and severe fluid retention. He was getting inhaled bronchodilator therapy for breathing difficulty. After being dialyzed he was discharged on a Friday and scheduled for Monday dialysis. On Sunday he was unresponsive with a diastolic bp of 60.

With the efforts of family members, his nephew who is an NP, and the patient's PCP, it was determined that the 30 lbs. of fluid removed from Roland in the hospital had overwhelmed the necessity for all of the blood pressure medications Roland was taking. The recommendation was made to bring Roland back to the hospital, but his family, responding to Roland's wishes, instead removed him from all medications except his breathing meds. To the family's surprise and delight, the next morning Roland was awake and responsive.

He was on 26 medications at the time. His family along with his PCP decided to discontinue most of his blood pressure medicines. Each of the nine specialists failed to treat Roland as a whole patient; instead treated him in body parts. They completely missed the fact that the dialysis had removed 30 lbs. of fluids, causing him to become hypotensive and nearly die.

After all of this, Roland was left on his digoxin for his heart failure, meds for restless legs, and his respiratory medications. He lived independently at home with a very high quality of life, spending important time with his family for his remaining 18 months.

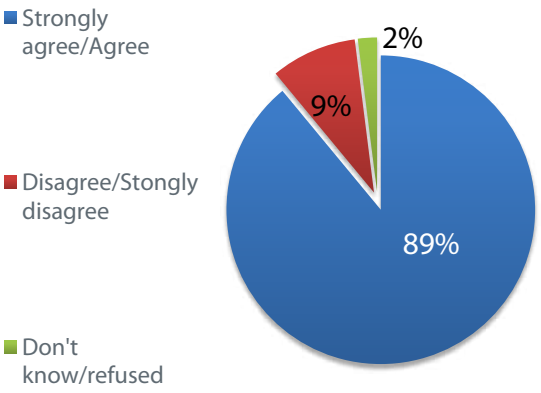
This is an all too common story that depicts real patient consequences of the complex labyrinth of health care with which we live.

They completely missed the fact that the dialysis had removed 30 lbs. of fluids, causing him to become hypotensive and nearly die.

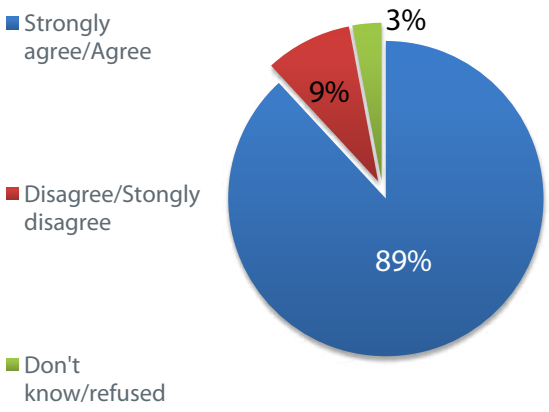
** Not his real name.*

AMERICANS VALUE THEIR RIGHT TO CARE IN THE HOME

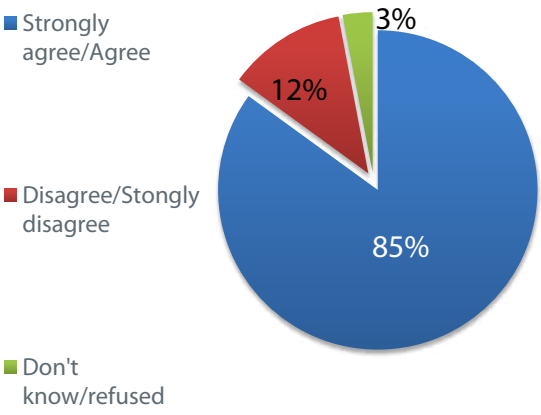
Americans should have the right to home health if needed as they get older



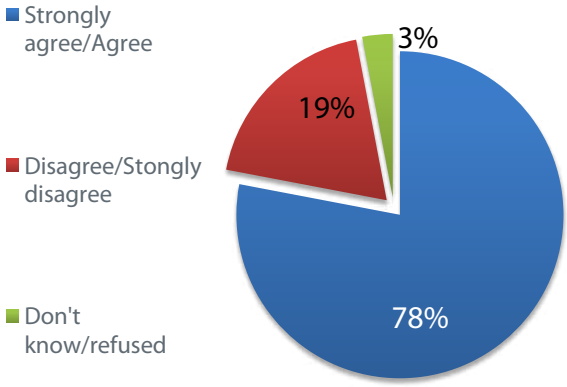
Home health care is a valuable resource for me, my family and future generations



Health care in the home is a right that I want to protect for me and my family



Americans have a right to home health that is funded by the government, such as Medicare/Medicaid



NEEDED
Patient-Centered Care That Transcends Organizational Boundaries

A monumental shift in how we view health care delivery is necessary if we are going to successfully address these current challenges. Any new model must look beyond a particular episode and manage a patient's disease process from beginning through end of life, if necessary.

Practical and Conceptual Models for Success

Although none of the Medicare demonstration pilots have yielded a solution that can be applied across systems and patient populations, some instructive models have emerged.

Geisinger Health System, Pennsylvania — To date, Geisinger has demonstrated a 20 percent reduction in hospital admissions (all causes) and a seven percent reduction in total medical cost savings.[viii] These accomplishments follow implementation of some fundamental changes, including the:

- *Use of a unique patient-centered medical home concept,*
- *Assignment of a "personal health navigator" to each patient,*
- *Integration and redesign of care processes, focusing on the use of technology, and*
- *Emphasis on use of evidence-based care coordination.*

Transitional care is defined as:
The area of health care 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.

Department of Veterans Affairs (VA) — Data from a 2006 study show a 27 percent reduction in hospital admissions and a 69 percent reduction in inpatient days of care.[ix] The VA attributes these improvements to their Home Based Primary Care (HBPC) program, which targets frail, chronically ill veterans and delivers long-term health care services in the home. This model provides ongoing, continuous monitoring and relies on a care team that includes medical directors, program directors, nurse practitioners, physicians' assistants, RNs, licensed practical nurses, social workers, dieticians, rehabilitation professionals, pharmacists, and program assistants.

The "Other Medical Home" — This recently-proposed concept advocates the expanded allocation of in-home health care resources for Medicare's most chronically ill patients. The concept calls for adoption of the Independence at Home legislation, relaxation of Medicare's "homebound" status, and expansion of the home care episode to include continuous, routine care management.[x]

Care Transitions — With a focus on clinically vulnerable patients through the care continuum, this model is concerned with events that occur between transfers from one health care setting to another, also known as transitional care.[xi] Transitional care is defined as:

"The area of health care 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."[xii]

The Care Transitions model focuses on the core considerations of (1) medication management; (2) use of patient-centered personal health records; (3) emphasis on timely physician follow up –- both specialty and primary care; and (4) an understanding of the red flags that indicate an exacerbation of a patient's condition, as well as responses.[xiii]

C_4M®

A COMPREHENSIVE SOLUTION

The promising models listed above rely on interdisciplinary health teams, targeted technology and home based clinical monitoring. From a position of experience and expertise, Amedisys has expanded on these basic chronic care management principles to create **C_4M®, a new model of care for managing chronically ill patients at home.** Amedisys believes they are poised to facilitate the delivery of a new care model that allows chronically ill patients to be treated at home by an integrated team of health professionals, while reducing the cost of fragmented care and unnecessary hospitalizations. This model can address the needs of patients beginning in the early stages of a diagnosis and continuing through the end of life. By integrating hospice care within the C_4M® team, this model allows for patient and family participation in decision-making, meeting their needs at the most crucial time.

Why at home?

One of the benefits of the C_4M® model is that it reaches patients where they live. An extensive in-home assessment evaluates a patient's clinical, functional, psychosocial and behavioral status as well as caregiver support. While in the home, clinicians may observe safety hazards, medication discrepancies, and/or social and environmental challenges unrecognizable in an office-based setting.

According to the AARP, 89 percent of Americans older than age 50 would like to stay in their homes as long as possible.[xiv] Home-based care represents a cost-effective alternative to other post-acute care settings and may offer cost savings versus traditional office visits for broader chronic care management. The Veteran's Health Administration (VHA), for example, has started to use "telehealth" technologies to provide patients at home with increased access to specialists while controlling costs. By expanding the use of telehealth over a six-year period, the VHA was able to reduce health system utilization by 30 percent, while achieving patient satisfaction scores of 86 percent.[xv]

What separates $C_4M^®$ from other models of chronic care management?

Availability of real-time patient data through information and communication capabilities – A $C_4M^®$ technology platform will make available real-time data that allows for the continual communication with patients, providers and will connect the patient and their clinical information with all members of the care team. This "defragmentation" of the data stream will ensure every patient gets the care they need at the right time.

Ability for early recognition and rapid deployment – Within the $C_4M^®$ model, a clinically appropriate health care professional (physician, nurse, social worker, etc.) can be immediately deployed to a patient's home, preventing unnecessary exacerbations, ER visits and hospitalizations.

Physician driven – The patient-centered medical home is driven by the relationship between patients and their primary care physicians. The $C_4M^®$ model is a partnership between the patient's physician and all of the members of the patient's care team. Amedisys, with its technology solutions and focus on guidelines-based care can ensure seamless quality of care in the collaborative arrangement with multiple physician practices and hospitals.

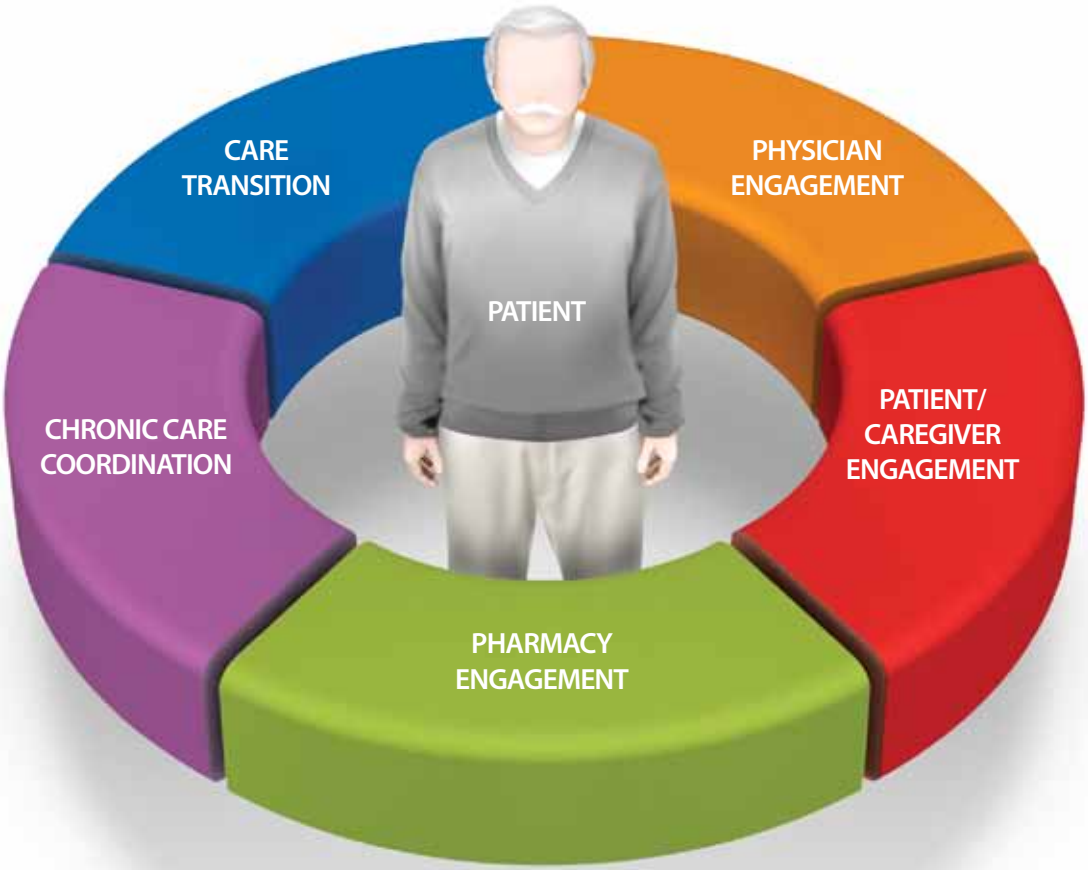
Relationship based – Engaging patients and their caregivers is the hallmark of Amedisys' care. The $C_4M^®$ model leverages the unique relationship forged between elderly patients, their physicians and home-based clinicians. Unlike facility-based settings, clinicians who deliver care in a patient's home are able to build a unique bond with their patients which leads to a more trusting and open relationship. Patients often rely on home care clinicians to assist with understanding and implementing physician's orders. A new model of care that forges this type of relationship creates opportunities for learning, coaching and behavioral modification.

A model that focuses on managing chronically ill patients at home leverages the $350 billion in voluntary caregiver services and support provided by family and friends each year.[xvi] 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 importance of their role and provides them the support and education in one coordinated touchpoint they need to care for their family member.

Additionally, by building on an existing home-based infrastructure, the Amedisys $C_4M^®$ model can be integrated into multiple health care settings and demonstration projects that seek to deliver high quality, cost effective chronic care management. The model can expand to a nationwide coverage area of health clinicians that can be deployed to a patient's home anywhere.

OVERVIEW OF $C_4M^®$ COORDINATION POINTS

Amedisys has identified the following core elements as the basis for $C_4M^®$:



CARE TRANSITION

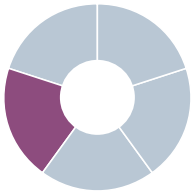
Care Transitions focuses on ensuring a patient has a smooth transition between all care settings. As a *New England Journal of Medicine (NEJM)* article illustrates, "a safe transition from a hospital to the community or a nursing home requires care that centers on the patient and transcends organizational boundaries."[xvii] 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. Patients are most vulnerable at the point of discharge from a hospital, and, in many cases, those who are transitioned to a home or community-based setting are ill-prepared to self-manage their condition. Targeted interventions at discharge can reduce re-hospitalization rates; coordination of care interventions in a limited community- based setting has not shown similar results.[xviii]

PHYSICIAN ENGAGEMENT

In today's norm of hospitalists, physicians treating a patient during his hospital stay may not be the same physicians treating the patient once he is discharged. As noted in the NEJM article, "re-hospitalization is a frequent, costly, and sometimes life-threatening event that is associated with gaps in follow-up care."[xix] Hospital and physician collaboration is important to improve the effectiveness of a patient's follow-up care.[xx]

In a one year period, the average Medicare beneficiary sees seven different physicians and fills at least 20 prescriptions

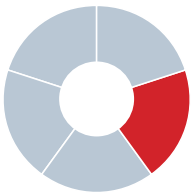
CHRONIC CARE COORDINATION



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."[xxi]

Amedisys conducts a detailed assessment on every patient in the C_4M® program. Using first-hand data gathered in the assessment, Amedisys' skilled nursing staff prepares a patient-centered care plan that considers all aspects of the patient's health condition, his/her social and emotional environment, and home dynamics.

PATIENT/CAREGIVER ENGAGEMENT



By engaging the patient and caregiver, they move from a role of passive observer in their health to a role of an active, informed manager of their health. Patients are taught specific skill sets to be able to make informed decisions, set goals and decide upon actions needed to reach their goals. Clinicians deliver coaching in a patient's home based upon on established plan of care – teaching patients and caregivers 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 where they live, clinicians can observe dietary trends: what a patient and caregiver eats, how they cook, and how active they are. They can also evaluate the safety of their patient's home. This is critical to understanding what self-management strategies should be employed for each specific patient based on their individual needs.

PHARMACY MANAGEMENT

The importance of pharmacy management and patient compliance has become increasingly evident, as multiple studies have connected lower hospitalization rates with adherence to medication regimes. Cardiovascular patients that do not take their prescription as clinically directed are 11 percent more likely to be rehospitalized,[xxii] while only 39 percent of patients are likely to adhere to their prescription directives after 24 months.[xxiii] Further studies have illustrated that overall expenditures decrease as medication adherence improves, as each $1.00 spent on medications prevents $1.14 spent on hospitalizations.[xxiv]

Amedysis' clinicians understand the importance of ensuring patient awareness of the importance and details of medication management. The C_4M technologies also allow for enhanced integration of pharmacy management into each patient's care plan and electronic monitoring of prescription adherence. By promoting appropriate utilization of medications, Amedysis is working to improve health outcomes while providing efficient care.

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INFORMATION AND COMMUNICATION TECHNOLOGY
How We Facilitate C_4M®

With additional integrated capabilities, we foresee the existing home care infrastructure serving as a platform for a scalable, nationwide system of managing chronically ill patients. Amedisys has identified additional capabilities needed to form the complete clinical engine for comprehensive, continuous chronic care management in the home and is actively pursuing full model development. Below is a description of various technology components currently used or within the process of being developed:

1. Clinical Documentation System-Point of Care (POC)

Amedisys has developed an electronic version of clinical documentation referred to as its Point of Care (POC) System. This application is a mature and robust clinical tool used by field clinicians. Providing clinicians with laptop devices, POC is used to document the patient medical record, schedule visits, and document medications, clinicians' care notes, and medical orders.

Point of Care supports patient safety by integrating robust support tools such as medication interactions, allergy warnings, and duplicate medications. This real-time patient information can be used to promote greater clinical integration and/or data sharing. Point of Care has been successfully deployed to over 12,000 clinicians.

2. Provider Communication Technology: Mercury Doc

Amedisy has also developed some of its own Applications, such as Mercury Doc. Mercury Doc allows physicians to process certifications and recertifications, process patient orders, and provide clinical trending information such as vital signs. Mercury Doc also allows the physician to provide oversight of the applicable care plan.

Mercury Doc has been overwhelmingly successful with physicians because of its simplicity of use. Continuing enhancements are based upon physician feedback and direct input. Mercury Doc currently has over 7,000 physician end users, and is responsible for an estimated 500,000 orders processed monthly, and over 50,000 admits annually.

The Centers for Medicare and Medicaid Services (CMS) is providing reimbursement incentives for some providers that are meaningful users of electronic health records. Mercury Doc supports this meaningful use standard by enabling the provider to process home health and hospice orders electronically. Mercury Doc also assists clients in preparing Medicare reimbursement filings.

3. Expanded Collaborative Care Technology: SymphonyDoc

As a benchmark in its strategic technology delivery to physicians, Amedisys will provide an industry first: an integrated physician portal/care collaboration/electronic health record system that is designed to meets the needs of the home health and house call provider. Branded as SymphonyDoc, this application will incorporate the functionality of Mercury Doc in 485 processing, CPO Oversight, and orders processing, plus leverage capabilities such as managing the provider clinical worklist, e-prescribe, disease management, clinical registries, care plan monitoring, and clinical database reporting.

Mirroring the success of Mercury Doc, SymphonyDoc is being developed with significant input by the physician community. SymphonyDoc will be easy to use and will be designed to support the needs of the home health/hospice provider.

The advent of meaningful use affects SymphonyDoc development. Amedisys Clinical Informatics Team is well versed in the specifics of Meaningful Use and work to design SymphonyDoc to support its requirements. For example, SymphonyDoc will give providers the capability to "push" educational content and reminders to patients as well as their care teams.

SymphonyDoc represents a significant technology expansion for Amedisys. The platform of a robust provider portal, combined with attributes of an electronic health record encompassing a home health/hospice focus will speak directly to the needs of our provider customers and the patients we jointly serve. SymphonyDoc will be the technology platform that not only offers identifiable "products" or "modules" to referring sources, the relatively unique design of the Application itself is envisioned as a functional demonstration how clinical technology supports CMS and meaningful use objectives.

4. Business Intelligence, Interoperability and Analytics: Quality Management & Analytics (QMA)

Amedisys continues to develop highly sophisticated business analytics and clinical quality metrics. With possibly the largest proprietary clinical repository in the home health sector, Amedisys deploys a dedicated department of clinical and business analysts with a focus to continually measure quality and care delivery parameters.

This intense level of analytics drives Amedisys operationally as well as technically. New applications have been created as a result of identifiable needs driven by business intelligence. Operations management is largely supported by clinical analytics. Effective delivery of care, effective implementation of new clinical tracks, and research into proposed new specialty clinical programs, are supported by data maintained by internal QMA.

These dashboards include Chronic Care Management, Coumadin Management, Pharmacy Management, Clinical Management, Quality Care Management, and Clinical Interoperability to interface with the healthcare ecosystems.

5. 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 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 visit follow-up with patients and caregivers.

The value of the Encore call center lies in the ability to reduce hospitalizations by delivering continuous care coordination to chronically ill, elderly patients. Preliminary internal data from the Encore call center supports the premise that continuous post-episodic communication with patients may lead to a reduction in re-hospitalization.

6. Telehealth Monitoring

Amedisys provides monitoring systems that create a link between homebound patients and their physicians via home care clinicians. Routine monitoring educates patients about their needs and helps them become more informed consumers of health care. Additionally, physicians have access to trended patient data and outcomes, facilitating more informed treatment decisions.

7. Additional Integration Opportunities

Integration of additional point of care diagnostic testing, including portable x-ray technology, MRI and CT scans, and specialized laboratory tests could expand the scope of care coordination, paving the way for enhanced mobile medicine capabilities in the home. Additionally, integrating health information technology systems could help improve care coordination by facilitating communication between providers and patients. Janet M. Marchibroda, Chief Executive Officer of the EHealth Initiative and the EHealth Initiative Foundation, Washington, D.C. describes some of the advantages of information technology:

"Health information exchange initiatives offer a platform for efficiently and effectively sharing critical health information about patients and their care, while managing privacy and confidentiality from across the health care system with those who deliver their care, regardless of setting. Alignment of health information exchange efforts with those related to chronic care management will enable access to critical information such as lab test results, visits, and prescriptions orders. Health information exchange initiatives can also be leveraged to deliver alerts and reminders to the clinician based on information in the system."[xxv]

Amedisys is the only nationwide network that provides monitoring systems that create a link between homebound patients and their physicians via home care clinicians.

HONORING PATIENT PREFERENCES WHILE REDUCING COSTS

Remembering Roland, and the Role of Amedisys and C_4M®

Amedisys believes that innovative providers in the home care industry have a unique opportunity to evolve into more active stakeholders within the health care continuum, serving as alternative providers to facility-based care for chronically ill patients. To facilitate this evolution, Amedisys is actively working to integrate its C_4M® model into key pilot projects and hospital reduction initiatives of health plans and hospital systems.

Amedisys and C_4M® are positioned to be the provider and care model of choice for elderly patients who are living with chronic disease. Recognizing that solutions will only emerge when we re-think how health care financing 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. Thus, Amedisys is focused on being the low cost provider of high-quality health care services. The vast majority of Americans prefer community-based care to facility-based care. C_4M® honors this patient preference, reaching patients where they live and enabling people, like Roland, to live their lives as independently as they wish. That we also achieve significant cost savings is merely a natural by-product of this patient-centered approach.

[CALL TO ACTION - TBD]

ABOUT AMEDISYS, INC.

Amedisys, Inc. (NASDAQ: AMED) is the nation's leading health care company focused on bringing home the continuum of care. Each day Amedisys delivers personalized health care services to more than 35,000 individual patients and their families, in the comfort of patients' homes. Amedisys has two divisions, home health care and hospice. The Company's state-of-the-art advanced chronic care management programs and leading-edge technology enables it to deliver quality care based upon the latest evidence-based best practices. Amedisys is a recognized innovator, being one of the first in the industry to equip its clinicians with point-of-care laptop technology and referring physicians with an internet portal that enables real-time coordination of patient care seamlessly. Amedisys also has the industry's first-ever nationwide Care Transitions program. Amedisys Care Transitions is designed to reduce unnecessary hospital readmissions through patient and caregiver health coaching and care coordination, which starts in the hospital and continues throughout completion of the patient's home health plan of care. For more information about the Company, please visit: www.amedisys.com.

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Amedisys
Bringing Home the Continuum of Care

5959 South Sherwood Forest Blvd.
Baton Rouge, LA 70816
(225) 292-2031
amedisys.com