AMG - Integrated Healthcare Management

Committed to Excellence

Our Mission is to Heal

We put patient care first at all times.

Our Purpose

To operate cost effective post-acute facilities with excellent patient care.

Ever Expanding

Over 1800 employees and 19 facilities, but it's only a start.

Our People Are Special

We invest in and reward loyalty, knowledge, performance and a desire for growth.

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INTEGRATED HEALTHCARE MANAGEMENT

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Corporate Newsletter-2015

Message From The COO

AMG

Integrated Healthcare Management

Gene Smith

Wow, what a year! Together we accomplished a lot, and yet, there is so much left to do. This was truly a year of expansion and transition so let me provide a few bullet points:

- We added 4 LTAC hospitals:
  - -Las Vegas, NV- a 24 bed hospital acquisition that took place in May.
  - -Covington, LA- a 38 bed hospital acquired from Select on November 1st.
  - -Mercy, Oklahoma City, OK - an 18 bed satellite of our Edmond, OK hospital that opened the end of October.
  - -North Alabama Specialty Hospital- a 31 bed start-up LTACH in Athens, AL. This is the first LTACH start-up AMG has been involved with.
- Began construction on a new 24 bed rehabilitation hospital in Covington, LA. This should open in February of 2016. It will be called AMG Physical Rehabilitation Hospital.
- Began construction on a new 16 bed LTACH in Zachary, La. We will move our Feliciana hospital from its current location to this new location in February of 2016.
- We sold or closed two hospitals that were not financially viable during the course of the year.

Probably the biggest 2015 news item affecting our LTAC hospitals was the legislation passed earlier in the year that will have a direct impact on how we will be reimbursed in 2016. The new methodology is too complicated for me to delve into here, but it will have a profound impact on the types of patients we can treat, the amounts we will be paid and the impact on our length of stay. We will continue to build our more involved patient population and ventilator population. However, we will also be able to treat a whole new group of patients that we have not been able to treat in the past due to length of stay requirements. I'm looking forward to working with all of you in transitioning our hospitals to this new methodology. You will learn more on the new payment methods as your hospital nears the end of its fiscal year.

I believe 2016 will position us as one of the leaders in the post-acute hospital market. We will need to think and manage differently, but that is not rare in the medical business where payment changes have spawned entrepreneurial processes to adapt to the changing reimbursement environment. In my forty years of working in healthcare this has occurred many times.

Now that we are in the holiday season, I want to wish you and your families a very Merry Christmas and a Happy New Year. Take care and be careful while celebrating these festive holidays.

Gene Smith
COO
AMG

FROM THE NEWSROOM OF QUALITY CONTROL

Lots of changes ahead for 2016! The FY 2016 Final Rule for LTACHs and the FY 2016 Final Rule for IRFs was recently released. CMS finalized several new changes for next year. There were 5 new Quality Measures finalized for the LTACHs and 6 new Quality Measures for the Rehabs. See below for tables of new measures that will be required for next year. CMS also finalized plans for public reporting and extended the data submission deadlines.

LTACH **Quality Measure**	Data Submission **Start Date**	**Data Collection Method**
Ventilator-associated events	**1-1-16**	**NHSN**
% of patients experiencing 1 or more falls with injury (Will also need to know total # of falls since admission)	**4-1-16**	**LTCH Care Data**
% of LTCH Patients with an admission and discharge functional assessment and a care plan that addresses function	**4-1-16**	**LTCH Care Data**
Functional Status: Change in mobility (vent)	**4-1-16**	**LTCH Care Data**
30-day Readmissions: This measure assesses the rate of readmissions to STAC and LTCHs within 30 days of discharge from an LTCH.	**1-1-16**	**Claims Data**

IRF (Rehab) Quality Measures	Data Submission **Start Date**	**Data Collection Method**
% of patients experiencing 1 or more falls with injury (Will also need to know total # of falls since admission)	**10-1-16**	**IRF-PAI**
IRF Functional Measure-Change in self-care score **IRF Functional Measure-Change in Mobility score** **IRF Functional Measure-Discharge self-care score** **IRF Functional Measure-Discharge Mobility Score**	**10-1-16**	**IRF-PAI**
30-day Readmissions: This measure assesses the rate of readmissions to STACs, LTACs and IRFs **within 3**0 days of discharge from an IRF**.**	**1-1-16**	**Claims Data**

Public Reporting!

CMS will begin reporting each LTACH's and IRF's performance on certain Quality measures publicly no later that the fall of 2016! CMS indicates it may use its Hospital Compare website to display measure information. CMS specifically will report data on three measures:

Inpatient Rehabs:

- CAUTI and Pressure Ulcers: Data from calendar year 2015 will be reported
- 30-day Readmissions: IRF performance for calendar years 2013 and 2014

LTACHs:

- CAUTI, CLABSI, Pressure Ulcers: Data from calendar year 2015 will be reported
- 30-day Readmissions: LTACH performance for calendar years 2013 and 2014

Jennifer Wallace
Corporate Director of Quality

From the News Room of Health Information Management and HIPAA

The ICD-10 -CM and PCS code set is finally LIVE at last! Our AMG Coders now have approximately 141,000 codes to choose from when filing patient claims as compared to 17,000 with ICD-9. Although it has been years in the making, we are excited about the challenge of the transition.

The U.S. has been using ICD-9-CM since 1979, and it was not sufficiently robust to serve the health care needs of the future. The content was no longer clinically accurate and had limited data about patients' medical conditions and hospital inpatient procedures, the number of available codes was limited, and the coding structure was too restrictive. The U.S. could not directly compare morbidity diagnosis data to state and national mortality data, because mortality data had already transitioned to ICD-10 code sets. Further, most developed countries had already made the transition to ICD-10 code sets, so the U.S. couldn't compare U.S. morbidity diagnosis data at the international level.

ICD-10-CM/PCS code sets will enhance the quality of data for:

- Tracking public health conditions (complications, anatomical location)
- Improved data for epidemiological research (severity of illness, co-morbidities)
- Measuring outcomes and care provided to patients
- Making clinical decisions
- Identifying fraud and abuse
- Designing payment systems/processing claims

AMG has been preparing for this transition for the last two years. One of the most recent transition components was the expansion of our clinical documentation improvement (CDI) program, which included training the Case Managers, now CDI Specialists, at each Hospital to assist the Coders with the CDI function. So where did this term CDI come from? Historically, in the STAC setting, data collection occurred after the patient was discharged. After discharge, Coders/HIM professionals checked the record for discrepancies that could hinder code assignment. HIM professionals would then query the provider for clarification retrospectively. LTACs, since PPS, have implemented CDI programs through concurrent coding for LOS management and minimizing Short Stay Outliers. Cases are coded:

- Prior to admission with preliminary DRG assignment
- On day 4 of admission after receipt of H&P
- Every 7 days thereafter through discharge

A CDI Program helps bridge the cultural divide by equipping physicians, coders/HIM professionals, and documentation specialists with knowledge they need to achieve complete and accurate concurrent documentation in the medical record, to ensure accurate DRG assignment. Our Hospitals deserve to be reimbursed for the care we provide. If it isn't documented and coded, it didn't happen. The importance extends well beyond the immediate impact of reimbursement and a successful CDI program can have an impact on quality/ outcome measures, transition to ICD-10, resource consumption, data used for decision making in healthcare reform, and other national reporting initiatives that require the specificity of clinical documentation. Improving the accuracy of clinical documentation can also reduce compliance risks, minimize vulnerability during external audits, and provide insight into legal quality of care issues.

CHANGE is sometimes difficult, but we must embrace it! Remember, *"Change is the law of life. And those who look only to the past or present are certain to miss the future". John F. Kennedy*

If you talk to your coder or CDI specialist today, tell them THANK YOU!

Susan Wallis
Corporate Director of Health Information Management & HIPAA

FROM THE NEWSROOM OF PHARMACY SERVICES

Drug diversion and prescription drug abuse is a growing problem. CDC reports that 15,000 Americans die annually by overdosing on prescription pain killers. That's more than those dying from heroin, cocaine, and all other *illegal* drugs combined! Drug overdoses have become the largest cause of accidental death, surpassing traffic accidents! Many of these deaths are the result of obtaining prescription drugs illegally, including diverting them from the workplace.

Drug Diversion is defined as: Intentionally and without proper authorization, using or taking possession of a prescription medication or medical gas from company supplies, patients, or through the use of company related prescriptions, ordering, or dispensing machines (Omnicell/Pyxis). Drug diversion of any kind is considered theft.

AMG is not immune to drug diversion, since healthcare workers have proximity and access to controlled substances. A health care worker may divert a controlled substance for personal use; they may have a drug dependency, to sell the drug for financial gain, or to provide a supply to a friend or significant other. All of our hospitals have been involved in a drug diversion investigation at some time. As a result, we have declared **PHARMAGEDDON** on drug diversion!

AMG has implemented a proactive plan for the prevention of drug diversion in our hospitals which includes:

- Developing policies and procedures that guide employees in the expectation of maintaining a work environment that is drug and alcohol free.
- Developing policies and procedures to assist leadership in dealing with suspected diversion, or suspected impairment of employee's on duty (See AMG policies I.B.2.11.A, I.B.2.11.B and I.B.2.11.C). The policies also provide proper guidance for reporting.
- Developing a Behavioral Observation Checklist to assist supervisors identify behaviors that may indicate impairment of an employee.
- Assuring that partial dose wasting of controlled drugs are witnessed by another licensed professional.
- Performing regular audits of our automated medication dispensing machines for high usage of controlled substances by patient and by nurse.
- Performing reasonable suspicion drug testing based on specific, contemporaneous observations and facts concerning the appearance, behavior, speech, or body odors of the employee.

There are signs and symptoms of healthcare workers who divert drugs or are impaired at work. There are also tips for healthcare workers to utilize in identifying drug diversion and impairment. Your administrative team will be offering you training on this topic soon.

Finally, we have a legal obligation to not only conduct an investigation when diversion occurs, but to notify the respective regulatory agencies (Drug Enforcement, Police and respective Boards) of this incident. They will then determine whether or not they will join the investigation.

Remember, we all have a responsibility to provide a safe and protected environment for our patients and fellow workers, so please stay alert and notify your supervisor of any suspicious behaviors.

Rusty Petitjean
Director of Pharmacy Services

Karen Roth
Chief Nursing Officer

FROM THE NEWS ROOM OF CLINICAL SERVICES

Our new Regional Clinical Directors have been busy with the initiation of AMG's critical concepts education training program. April Ebeling RN, CCRN, a native of Lafayette with 14 years of critical care experience, has been working with the clinical staff mainly in Lafayette, but in the next couple of weeks will be hitting the road and tackling the rest of the Louisiana AMG facilities. Leah Formby RN, also a native of Lafayette with 6 years critical care experience, is our road warrior. So far she has already traveled to our facilities in Athens, Albuquerque, Las Vegas, and Greenwood with plans to be in Tulsa and Edmond in the next two weeks.

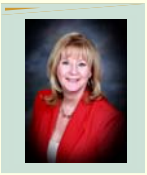
Interruption of stay often occurs because our staff lack the assessment skills to see a patient deteriorating prior to crashing. April and Leah's priority at the moment is to provide classroom and bedside education to the RN's, RT's, and LPN's to increase their critical thinking skills and decrease transferring the patient to a short term acute care facility. "Our RN's and RT's are excited for this opportunity," says Leah Formby. "Through this process the clinical staff can add additional education to their resumes." Leah and April are providing the clinical staff with the tools they need to manage higher acuity patients on ventilators and high risk vasoactive IV drip medications. Their focus is on addressing immediate patient needs and recognizing potential critical conditions.

So far the education plan has rolled out topics on early recognition, BIPAP, CPAP, and ventilator management. Also classes on the proper use of sedation on a ventilated patient with plans of covering topics on vasoactive IV drips, sepsis, and EKG interpretation. "I am very optimistic about the direction we are going and see great things in our future here at AMG," states April Ebeling.

Quality care is AMG's product. We accept and treat challenging, complex patients. By recognizing we have gaps in skill level and performance of some clinical staff, we can provide education and training, combined with hands on experience allowing us to bridge that gap. "We are confident that the clinical staff is capable of managing these higher acuity patients and eager to provide outstanding patient outcomes," states Leah Formby.

AMG is proud to offer this opportunity to their clinical staff, and with the help of April and Leah we are excited to build a stronger group of acute care clinicians.

Karen Roth
Chief Nursing Officer



FROM THE NEWS ROOM OF CORPORATE OPERATIONS

As our industry is faced with many new challenges both present and future, it is our duty to consistently identify opportunities for financial, human, and material resource conservation. In keeping with the department's focus on finding every dollar available to be reallocated to patient care, AMG has invested significant resources to revitalize, and enhance its value to our operations, both short and long term. There is much to do, as we continue to develop the infrastructure of the Supply Chain Management department, but the plan has begun to take shape more rapidly in the 3rd quarter of 2015, and many more value based activities are happening now and in the pipeline for the immediate future.

First and foremost, as previously announced, Kaleb Hargrave has joined the team as Assistant Director of Supply Chain Management, from his previously held position in IT. He has jumped in with both feet since making the transition in late July, and has been instrumental in the execution of many behind the scenes initiatives here at the corporate office, with a focus on preparation for the implementation of our next significant addition, ParScan. ParScan is a materials management information system (MMIS), that will be automating our purchasing processes for all Medline orders, and potentially other high volume vendors as well, through the use of its web-based system and handheld scanners, which are both preloaded with AMG's approved catalog of items before it is even utilized by any one location. Through this system, AMG will be able to prompt re-order points for our local end users in central supply, establish Par levels for inventory control, monitor formulary compliance, continuously manage a corporate wide standardized formulary, eliminate waste and confusion, conserve precious productive staffing hours, etc. If those weren't good enough features and benefits, ParScan has been made available to us by our partners at Medline Industries, at no additional cost, along with person to person training, a web based library of tutorial videos, and access to the help desk line for ready assistance. The best part about the ParScan implementation project is that it is already being used full bore in 5 locations as we speak – Edmond, Mercy, Houma, Wichita, & Tulsa. The implementation becomes easier and more seamless each time we go about it, and all other locations have tentative dates set for training and installation between now and mid-December. A 60 day rollout far exceeds my expectations when we made the decision to go in this direction!

I also wanted to take this opportunity to welcome Morgan Piner to the operations team, as she has made the transition from accounting, and is now serving as a Financial Reporting Analyst for AMG. Along with continuing to develop data analysis tools like the monthly Scorecards and supporting all spend management activities; she will be working on a number of projects aimed at improving processes and creating efficiencies. I am confident her efforts will prove very valuable to our facility staff, as well as our team here at the corporate office.

In closing, I would like to express my excitement about all of the upcoming opportunities we have to work together on. With the new, carefully chosen additions of personnel and support products now at our disposal, we are charging forward with a sound plan with aggressive, but realistic goals. We are already seeing immediate, and in some cases significant cost savings relative to the current initiatives. As with all new programs and initiatives, there is much to be accomplished, and it will require attention to detail and transparent communication throughout the entire team in order to be successful. Rest assured however, that the need to be swift will not supersede the need to be organized and effective, so that we continue to lay a foundation from which to improve. I sincerely look forward to developing new relationships with our leaders in the field, and serving you as a resource for quality outcomes.

Jared Sere'
Vice President Corporate Operations

AMG EMPLOYEE RECOGNITION

Dawn Hargrave began her AMG career in September of 1995 as an employee of our outpatient surgery center and physical therapy clinic. Dawn was in charge of all of the coding and billing for the centers. I joined in February of 1996 which at that point Dawn and I worked closely with Gus, III to develop the business and increase profitability. Eventually, the surgery center was sold and we moved on to hospital development. We began working on our first hospitals as ground-up construction projects in 2004. Since this was new territory, Dawn educated herself on the billing processes and procedures for post-acute hospitals and we successfully opened Lafayette Physical Rehabilitation Hospital and NeuroMedical Center Rehabilitation Hospital in 2006. In 2009, AMG was presented with opportunities to acquire five new hospitals within a span of only a few months. The rapid growth was difficult but quite an accomplishment. These acquisitions and every new acquisition thereafter (and they keep coming) provided evidence of the superior quality of our AMG billing and collections department under Dawn's leadership.

Every day continues to present new challenges and opportunities and Dawn handles all of them with the passion and loyalty to AMG that she has exhibited since day one over 20 years ago.

All of us here at AMG would like to thank Dawn for her 20 years of dedicated service. AMG truly appreciates you.

Jessica McGee
CFO & Sr. Vice President Corporate Operations