

Starting a Home Care Practice
Presented at AAHCP 5/12/05 Orlando, Florida as part of the AGS Conference

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Increasingly our patient population is becoming frail. The greatest percentage growth of any age group in the United States is the 85+ age group. Although there is wide variability in patients, the number of patients with ADL and IADL impairment is quite high and is going to increase. Often patients are having difficulty getting to medical appointments as their burden of illness increases. Home visits by primary providers (physicians, nurse practitioners, and physician assistants) is a useful means of increasing access to care to those that are the most frail in our population.

For the purposes of this article, “home limited” means that the patient requires the assistance of another individual to be able to make an office visit to a provider.

Type of Practice

If you enjoy spending more relaxed time with your patients and have the flexibility to tolerate the distractions of a home visit then you will be hooked and you will forever wonder why you waited to do home visits. If having the dog sniffing at your legs and more private areas is going to drive you into a tizzy then home visits are not for you. In addition to a willingness to tolerate uncertainty and non-conformity of your schedule, you will need to be able to organize your time well. If you can not drag yourself away from the chatty patient that still has more to tell you after two hours in a pleasant way, then home visits are not for you. You may be loved by your patients but you will not be able to make a living. You will find that the patient that previously was the disasters to the scheduling of your office will become your most fervent advocates.

Add on to existing practice

The easiest means of starting a homecare practice is to add home visits to your practice for those patients in your practice that are not able to get into your office without difficulty. You can block time within your schedule; see the patient at lunch or before or after your clinic. Very quickly you will know if you wish to do home visits full-time or extend the number of hours that you spend doing home visits. If you are a member of a group practice with a sizable number of home limited patients you may want to talk to your group about working with you to build a part-time or even full-time position to provide care for your groups’ patients similar to the way some groups use hospitalists. Your group may decide that they can add a member to the practice in a financially viable way without additional space concerns and minimal cost to allow your group to grow or

provide a value added service to position your group to be more competitive in tightly contested medical environments.

Full time Home Care practice

If you are ready to pursue your own full-time home care business you will have to make a decision as to the type of practice you want. You will need to be flexible and willing to change your business model dependent on your local market. In general, there are four types of practice: i) Boutique, ii) Urgent care, iii) Primary Care, and iv) Blended.

A *boutique care model* requires availability of patients willing to pay cash for the convenience of a visit in a home, office or. This is a cash (yes, credit cards are accepted) business. Cash flow is not an issue (assuming a sufficient supply of patients) as you are paid immediately. Billing is not an issue, and office staff can be minimal. Obviously, the biggest risk to this business is that you have over-estimated the number of cash paying customers in your area of choice.

An *urgent care model* can be part of or separate from a boutique practice. Contracting with insurers such as HMO's may be critical to success. Your ability to monitor metrics in your business will be key if you are hoping to work with HMO's but beware they are insurers with full-time actuarialists, statisticians and contracting experts and you (in all likelihood) are not. If you are hoping to see Medicare patients you will need to advertise unless your service is offered as part of a large group or hospital network. Your medical liability is likely going to be closer to ER providers as opposed to primary care. You will most likely have to provide some basic lab, EKG and X-ray services which will add to your start up costs but may add to your bottom line. Beware with Medicare because these services must be medically necessary. You can not do a chest X-ray every visit just because you have the machine!

A *primary care model* involves the provision (as much as possible) of services to home limited patient similar to those provided by office based physicians. Commercial insurers are currently not likely to pay for the service and the interest from HMO's is very regionally dependent. Medicaid patients may serve as a potential source of patients but in some states the reimbursement is extremely low. Depending on where you practice, the availability of basic medical testing such as X-ray, lab tests, and EKG's may be very limited. As with the urgent care model, the start up cost of providing these services and the possibility of scrutiny from Medicare and other insurers may be an issue. Clear documentation of the **Medical Necessity** of tests will help protect you from government audits.

A *blended care model* requires either a large group providing all these types of practice or an individual who is able to juggle the sometimes contradictory aspects of these models.

In the future the market may evolve to allow for the addition of or the development of practices in such areas as: hospital in the home, chronic illness management with or

without disease management, PACE without walls, complementary medicine, and disease counseling at the point of care. Specialists may elect to enter the home care area as well.

Supplementing your home visit revenue for the start up or as a long term strategy

If you have an interest in working in nursing homes either/or for long term care or sub-acute, then there may be opportunities to seek positions as a Medical Director of a nursing home. Availability is very dependent on your area. If you look after a significant number of sub-acute patients there may be opportunities to add to your home visit business as many of the patients who transition through a sub-acute unit will require home visits either temporarily or for the long term. When the patient improves where they are no longer home limited, they should be directed back to their previous physicians. Not only is this common medical courtesy but from a marketing stand point, you may be making office based physicians who do not do home visits aware of your home visit business. Assuming your former patient was pleased with your care, the return to the prior primary care doctor may encourage referrals for home visits from that provider.

A relation with a hospital practice gives you the same advantages seen with a nursing home association but adds the potential for financial support of your practice from a hospital. Particularly when there is a competitive hospital environment in your area, opportunities may exist for you to be recruited by a hospital or hospital system to add patients who are generally not easily accessible to them except via 911 to their bottom line. Home limited patients utilize hospital services to a large degree and your provision of home visits will aid the earlier discharge of patients which will add again to the bottom line of hospitals in a DRG world. You will be required to have privileges at the hospital(s) for a pre-determined period of time (often two years), and (depending on the state) you may have to sign a non-compete clause. The major advantages are: salary support, aid with practice development including marketing, and the possibility of referrals from groups associated with a hospital or hospital system.

Depending on your area(s) of interest, you may help pay the bills by pursuing directorships of hospices, nursing homes, or home health agencies. Part-time work may also be available in ER's, urgent care centers, and as a locum tenens. Be careful not to make commitments that provide short term benefit but limit your availability to the point that your patients will not be interested in working with you. Keep your eye on the ball! If you hope to have a business, your patients need to know that you are available.

Do you know what your end game is?

You should have some idea before you start what you hope to get out of your practice. Are you looking to conquer the world by being the largest provider of home visits in the world or are you looking to have a relaxed practice where you and perhaps a small number of partners will have a quiet practice that provides you with an adequate living. The capital outlays needed to develop a large organization are much greater and

monitoring cash flow is much more difficult and costly. You will constantly be making investments in technology and personnel before they are absolutely needed. A small practice is easier to grow on a shoe string and can be grown as the business and money are available. If you are not sure, then start small and delay the megalomania until later.

Financing the start up

Financing can be from personal resources, bank financing, investor capital, hospitals, insurers or grants. If you know your area well and have plenty of personal resources then this provides the greatest degree of control. Remember that you may be months before you see significant amounts of money from insurance payments. Medicare pays in a timely manner so it is wise to have your Medicare numbers in place prior to starting your practice. Our practice receives Medicare payments within 11-14 working days so it can be very advantageous to work with Medicare. If you have insurers in your area that can either be educated about the advantages to them of a home visit practice or already know (a rare breed in my experience) then they may be willing to pre-pay for services. Capitation arrangements can be advantageous but unless you are a large group with many lives, do not accept risk. Make sure you have a contract that makes sense for you. You will likely need an attorney to review the final document.

Bankers only want to lend you money when you do not need it. If you are planning on using a line of home equity to finance your practice, do it while you are employed, and make sure the time frame of the loan is reasonable for the time you expect your practice to be profitable. Beware that even a profitable business will be looked at with skepticism if you do not have at least three (3) years in your current business. The Small Business Association (SBA) can be helpful. Check on their website for local lenders.

Grants are generally more available to academic organizations and not-for-profit companies. However, if you are in an underserved area or are looking after an underserved population then there are grants available. Paying a professional grant writer (contact your local medical schools or university) is worthwhile if you are not experienced at grant writing. The AAHCP has many members experienced in grant writing and you may be able to get help via the list server.

Hospital supported practice development has been discussed <see above>.

Equipment

Office

Unless you have large amounts of capital, you will likely start (and may stay) as a business working out of a home office unless you already have a practice. You will need a computer, all-in-one (printer, copier, scanner, and fax machine), a telephone with at least two (2) lines, an answering machine or electronic equivalent, and once you get slightly larger, a fax press. <Our business fairly quickly could justify the purchase of an automated telephone system by the savings from our ever increasing on call service.>

Most of your electronic equipment should be new but used office furniture and cabinets make sense. Remember to discuss with your accountant the pros and cons of writing off your home office and any leasehold improvements. <Medical record keeping and an Electronic Medical Record will be discussed in another article.>

Medical

Your equipment needs vary according to the type of practice you have chosen to pursue. I have for all visits: a stethoscope, portable otoscope/ophthalmoscope, oximeter, measuring tape, nail clippers, a tympanic thermometer, reflex hammer, 3-4 syringes, injectable steroids, lidocaine, furosemide, adrenaline, diphenhydramine, promethazine, and a bulb ear irrigator all of which I carry in a fanny pack. In my car I have a portable water pick for more difficult impacted cerumen with disposable ear cures, a wound care bag and a procedure bag that contains everything I need to perform minor surgical procedures and cryosurgery. I very seldom have to go to my car for additional supplies unless I am doing a procedure or discover a new wound.

In our area we are able to get venipuncture, portable X-rays and EKG's performed by independent mobile companies. You may need to work with your hospital, a home health agency or develop the ability yourself if these services are not available in your area.

Avoid the desire to buy "cool toys". I did not and have several thousands of dollars of useless electronic junk to show for my carelessness. No matter how much financing you have become a penny pincher. You can always experiment when (if?) you are awash in cash. You will be altering your business plan continuously or you will not likely be successful. Keep your cash and credit available.

Office space and office staff

Until you need it, do NOT rent office space but BEWARE this decision will drive your banker crazy. Banks are NOT investors and they are NOT your friend. Banks expect to make a lot of money off you but they hate risk. You will not get money for an idea. Banks like bricks and mortar and see salaries for any of your employees as money down the drain. Unless you intend to see patients at an office plus do home visits you should work out of your home, sublet space from another doctor, or try to arrange with a local nursing home or assisted living a low or no cost space to use as your base of operations. However, try to get a telephone number that is yours and will be transferable to your new location when you are large enough to get office space.

When I read the AAHCP list server exchanges there are often providers that extol the virtues of doing everything themselves and not having office staff. I think this is very risky except at the very early stages of your practice if you have very little to do. A provider generates much more money seeing patients than the cost of office staff and you need not be interrupted constantly by telephone calls. The thought of doing the clerical functions of the office (which I did do when my home care practice was new) leaves me cold. Do what it takes to get the practice off the ground but hire basic office staff as soon

as you can. The patients will have someone else to talk to and develop rapport and you will be freed up to see more patients. The equation is simple: (ADDED REVENUE) – (PREVIOUS REVENUE) – (COST OF NEW EMPLOYEE) makes sense if the answer is greater than zero. If you intend to grow aggressively, you will be adding new employees before the revenue keeps up. If you are too aggressive you may be bankrupt. BE CAREFUL!

Recruitment of patients

Word of mouth is always the best source of referrals although it can be slow to evolve. Our practice did not have a good network of word of mouth referrals until the end of the first quarter of our third year. Something magical happens when your business has survived two years. Suddenly, people know about you and start to call. Keep plugging away and work hard to maintain your good reputation as ultimately this is the main marketing tool you have.

Discharge planners at hospitals, sub-acute units, and hospices can be a source. New providers are handicapped by the lack of a relationship unless they have a pre-existing relationship with one of the entities or unless you trained locally and are known. In some markets these people are a huge source of referrals but not in Arizona where I practice.

Home health agencies can be a large referral source but not in Arizona unfortunately. The marketing people are afraid of irritating local physicians who they count on signing their 485's (certification forms for home health). One home health agency in Arizona was moved to suggest our name to patients when we pointed out to them that we always sign their forms in a timely manner, and that we would be interested in seeing patients whose physicians would not be seeing the patient unless they improved. We also assured the agency that if the patient improved to the point that they were again suitable for office visits, that we would refer the patients back to their original PCP. We have started receiving a trickle of referrals from this home health agency.

Insurers who use case management (assuming you are contracted) can be an excellent source of referrals. Our business would not exist as currently constituted if we had not signed a contract to assume the care of a very difficult group of dual eligible (Medicare and Medicaid) patients. Our first 240 patients came from this one source which helped to provide the impetus to build our practice. We have aggressively worked to broaden our referral base and now we are approximately 2/3 Medicare without Medicaid and the remainder Medicare with Medicaid. When you are new to the market you may have to accept contracts that are not ideal or patients that are difficult to allow yourself time to develop your business and to start to receive word of mouth business.

The poor reimbursement limits aggressively pursuing assisted living (group homes, adult foster care, assisted living, and memory care units) but you may be able to justify going to the home by the increased volume of patients. Also, when you are first starting and are not busy it is better to be paid something than not at all.

Contracting

Medicare is still the dominant payer of home visits. Unless you are in a wealthy area where your patients can all pay privately you will need to enroll with Medicare. Medicare is very fair, very bureaucratic, and a timely payer. If your paperwork is not perfect you will go to the back of the line and start over. If you are not very fastidious your paperwork will not be processed. If you are unsure pay someone who does credentialing to do your paperwork. If you are going to use a billing agent they will generally do the credentialing paperwork for you either as part of your billing contract or for a separate fee. If it is not clear to you get the issue clarified in writing.

Medicaid can be very good to work with depending on your state, the level of reimbursement, and the level of bureaucracy that you need to endure to work with the program. If there are multiple programs providing Medicaid services in your area, try to determine the insurers that you can work with the best and try to contract with them. Patients that are dually eligible (Medicare and Medicaid) are generally easier to work with than straight Medicaid. Other insurers are worth considering if they are large in your area and they will pay for your services. Make sure that the CPT codes that you intend to use are paid by that insurer. Get it in writing as their Provider Representatives do not always know.

If patients are paying privately, get an Assignment of Benefits. This is the patient or their guarantor's agreement to pay you. Do not assume that just because someone is wealthy that you will be paid without difficulty. Some wealthy families have no trouble refusing to pay for your services. To date, our practice has not had to take anyone to collections and we would never consider it for our patients who have limited means. We have threatened such action on rare occasions when mean spirited family members refuse to pay for our services. A faxed copy of the Assignment of Benefits with their signature guaranteeing payment has been sufficient.

A decision you will need to make is whether to bill the services yourself (in house) or use a billing service. If you have experience with billing and coding and have billing software that you (you being yourself or your office staff) are comfortable using or can buy billing software (you can) at a reasonable cost then you should bill yourself. The accountability is much superior. If you are to use a billing service there are many issues to resolve. Are they paid per claim, a set monthly fee, or a percentage of billings or collections? Who if anyone will verify the patient's insurance? Who will enter the patient's billing information? Who does the coding and if you are having the billing service code, are the coders certified? Who receives the check? Are you able to get direct deposit or will the check be mailed? How many resubmissions will the billing company make and what is the charge if any for resubmitting? Do they also do credentialing?

This is complicated as you can see. Before you decide, do your homework from the resource list below. Before you make a decision, talk to colleagues who you trust about what they are doing and pick their brains. Get references before you sign and make sure you have an escape clause. If you are not happy even after your due diligence in choosing

a billing company then you need to get out and find someone else to work with. Your cash flow is the blood and oxygen of your company. Your business structure will not exist without them.

A wise woman (my wife) proudly announced to me that she had made more money for our business one day than I had. I disagreed as I had been out seeing patients and she had been sitting in the office doing valuable but non-billable tasks. She pointed out to me that she had spent time verifying insurance of the patients I was to see and discovered that 20% of the patients that I was to see (we had received the patients from my previous employer after they stopped doing home visits and I knew that they verified insurance) did not have insurance that I would be paid to see. By verifying the insurance, the billing process is smoother and the cost of collections goes down. Also, even though there may be times when you choose to see patients for whom you will not see, you should know who those patients are.

Although this article is not about billing for home care per se, there are two issues to remember. i) Medicare regards underbilling as seriously as overbilling as underbilling is perceived to give you a competitive advantage over your peers, and ii) please bill for the initial certification G0179, and the re-certification G0180, for home health agency form 485's. The payment is significant and there is very little required of you to legitimately bill for these forms. The AAHCP has great resources for home care billing.

Recruitment of providers

The quality of the individual is most important. I look for easy going, independent, self directed individuals who do not take themselves too seriously. Sir William Osler talked about the three A's: availability, affability, and ability. I still think he is right.

The largest impediment to recruitment of physicians is the cost and availability of malpractice insurance. Physicians also have to pay huge tail payments when they switch insurers which can limit mobility. Also, most physicians have to give 30 plus days notice prior to leaving their current employment, and credentialing can be very slow. Medicare can be slow particularly when the residents and fellows are all accepting jobs in the late fall and early spring. Physicians offer the advantage that they can sign all forms from Medicare and are generally experienced enough to handle the most difficult patients.

Midlevel providers (nurse practitioners and physician assistants) are paid comparably but have some important distinctions dependent on the state in which they work. (Check with the local state boards.) In Arizona, nurse practitioners can practice independently, write all narcotics, but are not able to sign some Medicare forms. Physician Assistants must practice under the supervision of a physician, which may be by telephone, and have significant restrictions on their ability to write prescriptions. Nurse practitioners are more flexible to integrate into the practice, however, our practice successfully employs both. The quality of the individual is key. I would find solutions to hire the best person available.

The actual recruitment is best done locally by word of mouth. If you are unable to find the right person locally you can advertise. Hospitals are sometimes willing to help with recruitment. Faxing residency program directors from primary care programs and geriatric fellowships is cheap and worthwhile. Recruiters and ads in professional journals can be very expensive but list servers can be useful for recruitment. Do not spend a lot of money wining and dining. Meet in your office or for coffee. Save your budget for retaining the staff that is working hard to build your business not the individual who is negotiating with you and several dozen other opportunities.

Ancillary services

The decision to add ancillary services is difficult, and like many things, a matter of timing. Unless your start up business plan has included X-ray, lab, and other diagnostic services, you will want to consider adding ancillary services. Although the decision is largely financial, our own interests will guide your decision making. For the addition of X-ray and lab services you should track the number and pattern of tests ordered prior to the addition of the services. Not only will be able to make more accurate financial decisions but it will help you defend yourself in an audit should Medicare or another insurer elect to question your service utilization. Document the medical necessity for any test (or consult for that matter), and never reward directly or indirectly providers for the quantity of tests ordered.

Leasing equipment often makes sense. You will want an option to buy at the end of the contract. However, technology is moving fast and it is sometime better to delay a purchase when the financial benefits are marginal as advances in technology may effect the financial decision.

Summary

A home care practice can be very fulfilling and you should be able to make an income similar to what you would make in an office practice working the same (or sometimes fewer) number of hours. Hire the best people that you can find and be flexible. Home care is likely to explode which will present many opportunities (some filled with mine fields). Go out and enjoy your new practice.

Resources

Online medically oriented business journals

Medical Economics	www.memag.com
Physicians Practice	www.physicianspractice.com
Family Practice Management	www.aafp.org/fpm.xml

Memberships in societies such as the AAHCP

- List server
- Member expertise

Consultants: the main caveat is make sure that they know more than you do

Books

Get Peter Boling's book it is the only one that I own for home care
Plenty of free and reduced rate material through the AAHCP